

# **Women's Agency and Power: Mapping gender regimes and health-related practices in rural Tamil Nadu, India**

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## **Dedication**

To my parents & brother:

My parents, for their love, support, and pride over the last three decades. My little brother, for staunchly believing that my 20/20 vision proves my DrPH to be the ultimate ruse.

## Foreword

*“They wore blouses with buttons down the front that suggested the possibilities of the word undone. These women could be undone; or not. They seemed to be able to choose.” – Margaret Atwood, The Handmaid’s Tale*

The original intention of this dissertation was to investigate structural, interpersonal, and individual level barriers and facilitators for cervical cancer screening among women in rural Tamil Nadu, India. This research question was formulated based on preliminary conversations I had with key informants at the private clinic in my study site starting in 2011. At that time, I had several discussions about the growing but still limited uptake of screening services and the need for further research on specific barriers to screening in this community. However, by the time I commenced doctoral fieldwork in the fall of 2013, several key changes had occurred at the study site that became apparent in the course of my research. The local public primary health clinic had made cervical cancer screening a priority in women’s health care, following renewed efforts by the Government of Tamil Nadu to deliver quality primary health care in public facilities through the Tamil Nadu Health Systems Project (TNHSP). During 2012, the public facility screened many of the community women as part of a preliminary patient screening protocol for all incoming patients, regardless of the health condition for which they were seeking care. I have described these involuntary screening activities and their implications in my paper on cervical cancer screening as an example of institutional power in rural Tamil Nadu. Involuntary screening in the public clinic not only made the recruitment for the original research question (i.e., women who had not been screened) more challenging, but also rendered the research question itself less salient. As a result, during the course of my fieldwork, I modified my research questions to investigate normative and structural constraints faced by women in this community that influenced their abilities to have

control over their health, wellbeing, and personal safety more broadly. In this new approach, my findings regarding the cervical cancer screening program eventually emerged as an example of how institutional power, and the constraints it places on women's bodies, impacts their ability to look after their own health and wellbeing. In addition to this, I have also focused on interpersonal (i.e., marital partnerships and family relationships) and community (i.e., social organization and norms in the village) level dynamics to present specific manifestations of the local gender regime that women may need to overcome to better care for their bodies and selves. This research has been partially funded by the Apollo Hospitals Educational & Research Foundation (AHERF) in India.

## **Gender Inequities, and Women's Health and Wellbeing: A review of literature on women's constraints in India**

There has been longstanding research and programmatic interest by global scholars regarding women and their bodies in India. My research focuses specifically on women's bodies and health in rural South India; I situate this work within a larger body of literature that has explored gender inequities, women's bodies, and health in India. My aim is to provide a broad framework that contextualizes the normative and structural constraints on women's bodies, health, and wellbeing. I begin by describing theoretical work from Michel Foucault and R.W. Connell, with a focus on the intersection of social institutions, power, and gender relations. Following this, I have attempted to trace empirical work that has been conducted in India that demonstrates deep gender inequities. I have also presented empirical work to demonstrate the impact of structural and interpersonal factors such as caste, gendered labor, and intimate partner violence on Indian women's abilities to look after their own health, personal safety, and wellbeing.

### **1. Theoretical Frameworks of Power, Social Institutions, and Gender**

#### **1.1 Michel Foucault: Power and the control of bodies**

The concept of power has historically been of interest to a wide variety of disciplines ranging from political science and military strategies to an array of social science disciplines. Nicollò Machiavelli and Thomas Hobbes produced classic writings on power in the political arena in the 16<sup>th</sup> and 17<sup>th</sup> century, and scholars such as Alfred Adler, Friedrich Nietzsche, Karl Marx and Max Weber have had a profound influence on the theorization of power in psychology, philosophy, and the social sciences. Within the social sciences, the conceptualization of power became a point of interest particularly after the Second World War. Although power was discussed primarily among political scientists and sociologists during this time, later scholars such as Michel Foucault



extended discourse about power to all social science fields and the humanities. Foucault's writings and discussion on the subject of power have become central to modern theorization of the concept (Sadan, 1997). Although his work is heavily influenced by Marx and Weber, Foucault's interest in the notion of power extends beyond the economic sphere and seeks to investigate how it is concretely and inseparably linked to social institutions such as prisons, schools, psychiatric facilities, and medical facilities (Crampton & Elden, 2007; Foucault, 1975, 1977, 1978).

Foucault's writings underscore three main aspects of power: it is productive, it is practiced rather than possessed as a right, and it is an inherent characteristic in every social relation. He explains the productive and intentional nature of modern power by clarifying that "There is no power that is exercised without a series of aims and objectives" (Foucault, 1978, pg. 95). Foucault also highlights that modern power is not held by individuals or institutions, but rather practiced or exercised consensually - rather than with brute force - and constituted within everyday social relations (Foucault, 1977). Furthermore, power relations are asymmetrical and dynamic, greatly influenced by local cultural norms, place, and time (Foucault, 1977; Sadan, 1997).

In discussing Foucault's contributions to how power is situated and practiced within social relations, it is useful to identify some key concepts from his work such as the links between power and knowledge, disciplinary power, categorization of the normal (and the identification of that which is abnormal), and bio-power. As a starting point of this discussion, however, it is important to note that much of Foucault's work is premised on the idea that sovereign power - i.e., power held and wielded by one individual to oppress other - has become increasingly ineffective in the context of complex modern socio-political and economic trends in society. In contrast, Foucault describes "productive" forms of modern power that comprise an interactive matrix of power relations that are intrapersonal and interpersonal (within individuals and groups), institutional, and

structural. Furthermore, Foucault argues that “modern power is tolerable on the condition that it mask itself – which it has done very effectively” (Dreyfus & Rabinow, 2014, p. 130). Due to its productive and relational nature, Foucault states that modern power is more challenging to identify and resist as compared to previous forms of overt power (Foucault, 1977).

Power and knowledge are often referred to by the combined *Power/knowledge* phrase in Foucault’s writings, reflecting his idea that the two notions are in fact inextricably connected, even via semantics (Sadan, 1997). He posits, “There is no power relation without the correlative constitution of a field of knowledge, nor any knowledge that does not presuppose and constitute at the same time, power relations” (Foucault, 1977, p. 27). In Foucauldian theory, power is both necessary for and reproduced by the production of knowledge. Moreover, the production of knowledge in disciplines such as medicine, psychiatry, or economics, among others, inherently contributes to the power of social institutions that are associated with these disciplines (Foucault, 1980).

Foucault also theorizes that *discipline* is a mechanism through which power can be exercised, particularly in social institutions such as schools, prisons, hospitals, or asylums. Foucault points to the importance of the intersection between power, discipline, and physical space. He postulates that discipline is a technique by which power can be exercised to monitor the behaviors of individuals. This monitoring could manifest in the organization of space (such as floor plans, architecture, or how people are distributed in the space), in time (scheduling or maintaining a timetable), and people’s behaviors and activities within the space (mobility or protocols) (Foucault, 1977). According to Foucault, like prisons or schools, hospitals present one example of highly regulated disciplinary institutions where individuals are constantly subject to

surveillance (Foucault, 1975; Foucault, 1980). He posits that hospitals exert discipline via space because,

It [is] necessary to avoid undue contact, contagion, physical proximity and overcrowding, while...at once dividing space up and keeping it open, ensuring a surveillance which would both be global and individualising while at the same time carefully separating individuals under observation. (Foucault, 1980, p. 146)

It is important to note that disciplinary processes in medical settings are not intended for overt oppression of patients by medical staff, but rather function as an inherent component of the system to advance the goals of the medical practice. Moreover, in the case of clinical settings, discipline is practiced by staff and patients as a means for patient health and wellbeing (Foucault, 1975, 1978).

The intersection of power/knowledge and discipline enables the identification of that which is “normal” and that which is not (i.e., abnormal or deviant). For example, Foucault discusses notions of normality extensively in his work on clinics as well as human sexuality (Foucault, 1975, 1978). He identifies scientific discourse on medical knowledge as acting hand in hand with disciplinary power, thereby enabling the medical institution to define and categorize risk groups as well as ideals of what is normal and abnormal (Foucault, 1975). Foucault also emphasizes the concept of normality in his work on prison systems. He posits that disciplinary power is enacted via mass surveillance of prisoners and the categorization of those who are normal versus abnormal, followed by punishment of those who violate the norms (Foucault, 1977; Sadan, 1997). It is important to note that disciplinary power is not necessarily characteristically negative – in fact, it may have several positive outcomes such as early diagnosis and effective treatment of disease through surveillance (Sadan, 1997).

In the context of public health, Foucault's conceptualization of bio-power is particularly relevant and encompasses various aspects of discipline, mass surveillance, medical knowledge and scientific discourse, and the control of bodies and populations. Foucault defines bio-power as "numerous and diverse techniques for achieving the subjugations of bodies and the control of populations" (Foucault, 1978, p. 140). Essentially, bio-power is a system of social control that emerges from institutional incentives on the part of the medical institution as well as the state to achieve specific population-level health outcomes such as low morbidity and mortality. Moreover, in the course of achieving these health outcomes, bio-power may be applied differentially across individuals or sub-groups depending on standards of normality and abnormality produced by the scientific discourse.

Foucault's work has been used by several scholars to study various aspects of Indian society. Much of this literature explores various dimensions and impacts of British colonization in India, including poverty, caste relations, gender and sexuality, and police surveillance (Arnold, 2012; Dirks, 2011; Gautam, 2014; Kaplan, 1995; Kumar & Verma, 2008; Pierce & Rao, 2006; Prakash, 1999; Puri, 2002). Foucault's theorization has also been used by scholars in the study of post-colonial India (Boyce, 2008; Brijnath & Manderson, 2008; Finn & Sarangi, 2008; Hegde, 1996; Lempert, 2006; Runkle, 2004). In his volume on the history of sexuality, Foucault expressed his intention to write a subsequent volume specifically about the history, sexualization, and medicalization of women's bodies that has subjected them to discourses and practices of bio-power (Foucault, 1978). Although Foucault ultimately did not develop this body of work, several ensuing researchers have invoked a Foucauldian framework to investigate reproductive and sexual politics, the intersection of women's bodies, medical practice and power, and women's empowerment to counter medical patriarchy globally (Bartky, 1988; Cheek & Rudge, 1994; Deutscher, 2010; Fahy,

2002; Gillespie, 1997; Hegde, 1996; Holmes & O’Byrne, 2006; Kaler, 2009; Lorentzen, 2008; Markula, 2001; Pringle, 1998; Tierney, 2004). For instance, one qualitative study by George (2002) in Mumbai, India utilized Foucault’s notion of bio-power to explain the everyday sexual disciplining that facilitated normalized marital sexuality among newly married adolescent women. Other research endeavors such as those by Ram (2001) and Basu (2005) have studied modern forms of contraceptive use among Indian women. Basu (2005) stated that contraceptive use in India, especially among the middle and lower classes, has moved beyond simple Foucauldian notions of state enforcement to a type of “misplaced modernity” that associates utilizing state-led family planning services with acting in a “modern” manner. This association, in turn, lends to individuals welcoming intrusive state policies and programs for family planning, thereby legitimizing deeply traditional forms of patriarchal subordination by the state. Another study by Saravanan (2013) uses bio-power as a key conceptual framework to discuss socio-ethical issues related to exploitation in commercial surrogacy arrangements in India. These studies suggest the different ways in which using Foucault’s framework enriches Indian scholars’ discourse around gendered hegemony and the legitimization of patriarchy.

## **1.2 R.W. Connell: Gender and power**

Any discussion about R.W. Connell’s theory of gender and power must be preceded with an understanding of social structure as Connell conceptualizes it. In her writings, Connell describes structure as,

more than another term for ‘pattern’ and refers to intractability of the social world... It reflects the experience of being up against something, of limits on freedom; and also the experience of being able to operate by proxy, to produce results one’s own capacities would not allow. (Connell, 1987, p. 92)

Connell clarifies that the matrix of constraints that comprise social structure operate via a variety of social institutions embodying complex interactions of power. Connell explains that her integrative theory of gender and power is an attempt to develop a formal and systematic conceptual framework to better understand and articulate gender relations (Connell, 1987). She identifies gender relations as an aspect of social structure that manifests in three distinct, but overlapping, domains: the sexual division of labor, the sexual division of power, and the structure of cathexis (Connell, 1987; Maharaj, 1995; Rosenthal & Levy, 2010). According to Connell, the sexual division of labor is gendered in nature and organization, and defined as “allocation of particular types of work to particular categories of people” (Connell, 1987, p.99). These types of work may be paid or unpaid, formal or informal, and in the domestic or non-domestic sphere. The sexual division of power describes a combination of structures of authority, control, and coercion that are gendered in nature. Common examples of the sexual division of power include intimate partner violence (IPV) against women or constraints on women’s abilities to make reproductive choices (Connell, 1987). The structure of cathexis is defined by Connell as the “construction of emotionally charged social relations with [other people]” (Connell, 1987, p. 112), which produces and is reproduced by social norms that legitimize the gendered nature of emotional attachments. For example, the structure of cathexis may shape norms regarding sexual and reproductive desires within a society. Furthermore, the structure of cathexis produces and is reproduced by social norms in an iterative process (Connell, 1987).

Connell explains that the three domains of gender relations are constituted at two levels – the societal and the institutional. At the societal level, the three domains of gender relations act through abstract social, political, and historical forces that shape division of power and generate norms that justify gender roles. Moreover, these structures of gender relations tend to weave into

the fabric of society and are generally longstanding in nature and slow to change. At the institutional level, these structures are practiced and maintained through a variety of processes in the media, in the work place, in school, within the family, and in religion, to name a few. In addition, evoking Foucault's notion of the regime of practice, gender relations are also reproduced through the everyday logic and actions that unfold within institutions (for example, the spatial organization of women's examination rooms in clinics may be dictated by the convenience of the clinical staff despite violating patient privacy) (Connell, 1987; Foucault, 1975; Wingood & DiClemente, 2000).

Connell (2009) has also theorized extensively about the gendered regimes of social institutions, defined as patterns of gendered arrangements that constitute a particular social structure. She explains that although gender regimes are a common component of organizational life, regimes are dynamic and can change over time. Examining gender regimes within an institution would entail investigating relationships associated with the institution – how people, groups, and organizations related to the institution are both distinct and connected. For example, tracing the gender regimes of the medical institution is useful for better understanding its impact on the delivery of health care – i.e., the gradual shift from traditional regimes of “masculine medicine” and “feminine nursing” have created the need for new modes of gendered conduct, especially for male nurses delivering care for female patients (Connell, 2012; Fisher, 2009). West & Zimmerman (1987) emphasize that gender is constituted and practiced in everyday interactions, and strongly influenced by the gender regime in which we are located. These scholars state that individuals are “held accountable” for their gendered conduct, given the gender regime they are acting under. Consequently, gender relations are created, reinforced, and perpetuated as individuals continuously participate in “gendered modes of behavior” (Hagemann-White, 1987).

Connell's more recent work has responded to the call for engaging with gender theory specifically in the study of health (Kuhlmann, 2002) with an emphasis on moving beyond the global North, where such work has typically focused, to the global South, where issues at the intersection of gender and health remain highly salient (Doyal, 2002). Connell (2012) states that gender is a form of structure that emerges from relationships that are to do with the reproductive differences between human bodies. As a result, she explains:

Gender practice is a reflexive process of social embodiment. Gender analyses specify how a society handles sexuality, reproduction, child growth, motherhood, fatherhood, and all that is socially connected with these processes. (Connell, 2012, p. 1677)

Therefore, gender analysis and theorization is crucial for understanding the mechanisms of active social processes that connect health-relevant practices to the reproductive domain. Moreover, several scholars have highlighted that although much of this work has primarily been conducted in the global North, issues emerging from the intersection of gender, health, and globalization are in fact global - therefore requiring a lens that is both globally and locally relevant (Connell, 2009, 2012; Doyal, 2002; Parker & Sommer, 2011; Patel, 2010; Prügl, 1999; Radcliffe, Laurie, & Andolina, 2004). For instance, research by scholars such as Chakravarti (2003) and Rao (2005) illustrates gender orders specific to the Indian context, where caste essentially shapes gender relations, particularly in the domain of marriage and family. Moreover, a sizeable body of work demonstrates that the intersection of gender and caste in India subsequently produces a hierarchy of differential health outcomes among women (for example, Balarajan, Selvaraj, & Subramanian, 2011; Mohindra, Haddad, & Narayana, 2006; Mohindra, Narayana, Anushreedha, & Haddad, 2011; Subramanian, Smith, & Subramanyam, 2006). Therefore, the differences in social and historical contexts in the global North and South, and the diversity of these contexts in the South,



suggests the need to extend gender theory to understand issues that have emerged in the South specifically (Connell, 2012; Mohanty, 2003; Naples & Desai, 2004).

## **2. Contextualizing Gender in India**

### **2.1 Gender inequities in India**

Similar to most other societies, gender inequities and low social and economic status of women has been a longstanding source of concern in India. A large body of existing research in India highlights prevailing inequities in domains such as women's mobility in public spheres, education, employment, violence against women, preference for sons, and neglected health (for example, Agrawal, Bloom, Suchindran, Curtis, & Angeles, 2014; Babu & Babu, 2011; Bhattacharya, 2006; Bijli & Tewari, 2015; Devika & Thampi, 2011; Dunn, 1993; Gupta & Yesudian, 2006; Gupta, 1995; Kantor, 2002; Krishnan, 2005; Mukherjee, 2012; Singh, Pallikadavath, Ram, & Ogollah, 2012; Sundaram & Vanneman, 2008). Since Indian Independence in 1947, the Indian Government has taken various measures to increase women's participation in education and employment as well as access to health services. Despite these efforts, women continue to fare poorly as compared to men across almost all domains of social life in India (Gupta & Yesudian, 2006). For example, efforts by the Indian government to increase literacy among girls and women have increased absolute rates of literacy, but women continue to lag behind men at 65.46 percent as compared to over 80 percent for men (Census Organization of India, 2011; Velkoff, 1998). Census data in India reveals that previously cited reasons such as girls not being allowed to attend school, early age at marriage for girls, and prioritization of resources for male children continue to plague many parts of India, particularly in rural areas. Moreover, prevailing norms regarding preference for sons have led several researchers to discuss the existence and impact of low sex ratios in India (for example, Guilmoto, 2011; Jha et al., 2011; Madan & Breuning, 2014; Paul & Saha, 2015; Vlassoff, 2013).

Scholars postulate that low sex ratios indicate high son preferences, therefore reflecting the pervasive devaluing of girls (Gupta & Yesudian, 2006). Despite the overall trend in gender inequities, it is important to note that India is a diverse country and degrees of gender inequities vary substantially by region. Differences appear to exist along the urban-rural divide (Census Organization of India, 2011; Olsen & Mehta, 2012), but also when comparing north and south Indian regions (Dyson & Moore, 1983; Anju Malhotra, Vanneman, & Kishor, 1995) and across states more generally (Arora, 2012; Saha, 2013; Singh, 2012).

## **2.2 Gender inequities and women's health**

The intersection of gender inequities and women's health have been of particular interest to several scholars, both in India and globally. These scholars have examined the many ways in which gender inequities, structural constraints, and power imbalances perpetuate vulnerability and poor health outcomes among women, specifically in the context of women's autonomy related to reproductive and sexual health (Amaro, 1995; Nanda et al., 2014; Duffy, 2005; Gómez & Marin, 1996). As Jejeebhoy, Koenig, & Elias (2003) explain, the lack of autonomy among women limits their decision-making power around their lifestyles and health behaviors, including but not limited to decisions around whether to participate in sex, negotiate condom use, engage in family planning, and control their decisions regarding fertility. Furthermore, cultural norms that perpetuate notions of female chastity present significant barriers with regard to access to sexual and reproductive knowledge and services. Additionally, skewed power relations and socio-cultural norms that favor men in many Indian communities are associated with the high prevalence of violence against women, further contributing to poor health outcomes (International Institute for Population & Sciences (IIPS) and Macro International, 2007; Maitra & Schensul, 2004; Nanda et al., 2014; Raj & McDougal, 2014; Santhya, Haberland, Ram, Sinha, & Mohanty, 2007).

## 2.3 Gender and Caste

The intersection of gender and caste presents a particular dimension of gender inequities that must be highlighted when discussing gender relations in India. The caste system is a distinctive feature of Indian society that derives from Hinduism and has been in existence for thousands of years. Although the Indian Constitution does not support caste-based hierarchies or discrimination, caste remains an important and strongly influential social structure in India. Caste comprises a key dimension of social status that is attributed to an individual at birth, stratifies the population along a hierarchy, and remains fixed during the lifetime of an individual. Although several smaller groupings (sub-castes) exist, historically there have been four major caste groups (listed here in the order of highest social status to lowest): *brahmins*, *kshatriyas*, *vaisyas*, and *shudras* (Srinivasan & Kumar, 1999). Soon after Indian Independence, the government amended the Indian Constitution and identified the lowest caste group, *shudras*, as “Scheduled Castes”, “Backward Castes”, or “Other Backward Castes”. These caste groups became eligible for affirmative action by the government and were given special provisions such as access to education, employment, and political representation via fixed institutional quotas in an effort to mitigate their overall marginalization (Srinivasan & Kumar, 1999).

Much of the feminist scholarship on caste in India has focused on *shudras* (commonly referred to as *Dalits* in India today) who have historically been subject to severe discrimination, exploitation, and social exclusion by other higher caste groups (Guru, 1995; Rao, 2005; Rege, 2006). Feminist scholarship in India has explored the gendered nature of caste inequities from a variety of perspectives such as kinship, poverty, women and labor, as well as sociological studies about women from various caste communities (Rao, 2005). Specifically, there is a vast body of scholarly work on *Dalit* women demonstrating how being a woman in combination with being

from the lowest caste intersects in complex mechanisms to push these women to the outermost margins of Indian society socially, economically, and politically. This work also documents in great detail the patterns of direct and indirect forms of violence on Dalit women's bodies (for example, Channa, 2005; Govinda, 2009; Guru, 1995; Narayan, 2006; Rege, 2000, 2006).

There are also numerous studies that provide empirical evidence emphasizing the relationship between gender, caste, and women's wellbeing in India (for example, Mohindra et al., 2006; Saroha, Altarac, & Sibley, 2008; Schmid, Egeland, Salomeyesudas, Satheesh, & Kuhnlein, 2006; Subramanian et al., 2006). In a study by Saroha et al. (2008) exploring the association between caste and utilization of maternal health care services among rural women in north India, the researchers found that upper caste women were three times more likely to utilize antenatal care and contraceptives, and five times more likely to utilize a trained birth attendant as compared to lower caste women. Another study by Mohindra et al. (2006) investigated how caste and socioeconomic position impacted women's health in a rural community in the southern state of Kerala. These researchers found that caste and socio-economic position were interconnected sources of disparity, but that being from an upper caste could buffer women with low socioeconomic status from poor health, whereas being from a lower caste exacerbated poor health outcomes (there appears to be no data on health outcomes for lower caste women with higher socioeconomic status). As scholarly work on gender and caste in India continues, close attention must be paid to the multiplicity and dynamic nature of caste relations in modern India, including the ways in which these changing relations continue to reproduce gender inequities (Rao, 2005).

### **3. Women's Empowerment in India**

Although women continue to face deep gender inequities in Indian society (particularly in marginalized groups based on caste and/or socioeconomic status), any discussion of women's

constraints must acknowledge the extensive work that has been done to socially and economically empower women in India. Women's empowerment has been examined in a wide range of literature in India. This body of literature has typically explored women's empowerment as either a result of developmental programs or as an intermediary factor influencing other developmental outcomes (Chakrabarti & Biswas, 2012). These studies have been qualitative, quantitative, or both, and have typically explored women's empowerment at the individual or household level (Chakrabarti & Biswas, 2012; Malhotra & Schuler, 2005). Moreover, these studies include a wide range of outcomes such as fertility or contraceptive use, nutrition, child health, women's health, and the impacts of specific policy implementations for women's empowerment (including policies for microfinance programs, education, health care, and women's employment) (for example, Holvoet, 2005; Jejeebhoy, 2002; Jejeebhoy & Sathar, 2001; Kabeer, 2005; Kishor & Gupta, 2004; Morgan, Stash, Smith, & Mason, 2002; Sharma, 2008).

A sizeable portion of the literature on women's empowerment in India is linked to widely adopted microfinance programs in the country. Following a major crisis in rural financial services, India followed the global trend towards the microcredit movement and initiated several self-help group (SHG)-bank linkage programs in the early 1990s (Karmakar, 1999). These programs became a key component of development agendas aiming to address poverty in emerging economies. Moreover, these programs targeted poor rural women based on the premise that women were more reliable credit recipients as compared to men, and were more likely to use and share the benefits of the loans with other household members such as children. Moreover, development programs believed that increasing women's participation in household economics would translate to overall women's empowerment and gender equality (Daley-Harris, 2006; Kabeer, 2005). There exists a vast body of evaluation research globally that demonstrates that microcredit programs are

associated with overall improvements in household incomes and livelihood diversification, and women's education, health, and economic activity (for example, Khandker, 1998; Mosley & Rock, 2004; Todd, 1996; Zaman, 2004). However, research on the impact of microcredit programs on women's empowerment and agency indicates mixed results (Kabeer, 2001; Pitt & Khandker, 1998; Pitt, Khandker, & Cartwright, 2006; Rahman, 1986).

Several researchers have questioned the effectiveness of microcredit programs in India for women's empowerment. In her critique of framing microcredit programs within the context of women's empowerment, Sengupta (2013) raises important questions for consideration. She states,

in many 'third world' contexts, it is assumed that poor women have minimum personal expenses and contribute more altruistically towards the overall welfare of the household than men. Given the ambiguity around the impact of loan, one can now ask whether the targeted women's economic well-being is an end by itself or a means to an end. In serving the larger/other end, is her end served at all? (Sengupta, 2013, p. 294)

This researcher also emphasizes that microcredit loans may in fact increase the burden of women's work and productivity without a corresponding increase in entitlements, control over resources, or decision-making. A number of other researchers have echoed these concerns about the impact of microcredit loans on women's empowerment in India. For example, Kantor's (2005) research on women's microenterprise in the state of Gujarat highlights the insufficiency of using economic indicators to measure microenterprise success. This researcher's findings demonstrated that an increase in microenterprise success could actually lead to decreased control over enterprise earnings among women. She concludes that microenterprise development programs must move beyond direct economic support for women to tackle the domain of power relations within families and households to strengthen women's decision-making power regarding how their income is

utilized in the family. Similarly, Garikipati (2008) refers to the “impact-paradox” in her study findings; the notion that although lending to women helps households across income groups, it does not empower women themselves, particularly the poorest women. This researcher emphasizes that because most loans women receive are used for family assets and women lack ownership of or control over family assets, women themselves rarely benefit from the credit loans. The ambiguity of findings relating microcredit programs to women’s empowerment call for policies that utilize these programs merely as one set of tools amidst a larger policy framework that addresses deep-rooted patriarchal ideologies that continue to constrain women’s autonomy and power within households and families (Ganle, Afriyie, & Segbefia, 2015; Garikipati, 2008; Sengupta, 2013).

#### **4. Women’s Work and Intimate Partner Violence (IPV) in India**

##### **4.1 Women’s paid and unpaid work**

Gender inequalities that disproportionately burden women with household and caregiving work have been conceptualized by several scholars such as Nussbaum (1999, 2000), Connell (1987) and Hochschild & Machung (1989). Nussbaum (1999) postulates that men’s strong preference that their wives take care of all child care and housework related duties is “constructed by social traditions of privilege and subordination” (p. 233), which in turn imposes the burden of a “double day” on women who are expected to also be economically productive (Nussbaum, 2000). Connell’s conceptualization of the sexual division of labor as a key structural domain of gender relations emphasizes not only the gendered nature of women’s work in the paid labor force, but also in the domestic and private spheres of women’s social lives (Connell, 1987). Similarly, Hochschild & Machung (1989) describe women’s combined burden of household work and elderly and child care that follow a working day as the “second shift”. As Nussbaum posits, “...women

are not treated as ends in their own right...Instead, they are treated as mere instruments of the ends of others – reproducers, caregivers, sexual outlets, agents of a family’s general prosperity” (Nussbaum, 2000, p. 220). She further emphasizes that the range of women’s social roles, and the various meanings and responsibilities ascribed to these roles, provide women with unequal human capabilities and opportunities as compared to men. Hindered capabilities may include the lack of opportunities to achieve good bodily health, engage in one’s senses, imagination, and thought, or being able to play and enjoy recreational activities (Nussbaum, 1999, 2000).

The disproportionate burden of economic, household, and care work on rural Indian women has been closely documented by a number of researchers (for example, Brinda, Rajkumar, Enemark, Attermann, & Jacob, 2014; Dhar, 2012; Gupta, Punetha, & Diwan, 2006; Shaji & Reddy, 2012). One study conducted in rural Maharashtra found that women in farming households not only spent more time doing farm work as compared to their husbands, but they were also responsible for almost all housework (Barker, Chorghade, Crozier, Leary, & Fall, 2006). In another study conducted by Srivastava & Srivastava (2010), the scholars found that although women’s primary duties were considered to be household-related, many women in rural areas needed to work outside of the home for economic reasons (Rahman & Rao, 2004; Srivastava & Srivastava, 2010). Moreover, the workforce participation rate was highest for Scheduled Caste women as compared to women from higher castes, largely because women from these lower caste groups came from impoverished households and had no choice but to engage in paid work. Furthermore, these researchers argued that women from lower castes did not face social taboos (and could not afford them, in any case) that prevented them from working, unlike women from higher castes. Among women who were working in rural areas, about 83 percent were employed in the agricultural sector (as cultivators or laborers) and 29.2 percent of these women were engaged in



casual labor (which is often less stable and may pay less compared to regularly employed labor) (Srivastava & Srivastava, 2010).

The intersection of women's paid work outside the home and unpaid household work raises a number of important questions about what women's empowerment actually means in this context. Much of the microcredit literature cites the importance of women's economic productivity for women's empowerment (for example, Datta & Gailey, 2012; Swain & Wallentin, 2009). However, prevailing gender roles and inequities that continue to hold women responsible for domestic and care giving work arguably render women disempowered despite their economic productivity. Moreover, a large body of work demonstrates that women's multiple roles related to child care, paid labor, and family and household obligations keep them busy for entire days. Often, these multiple work roles are a source of persistent mental and physical fatigue leading to several adverse effects such as depression, physical ailments, and social isolation (for example, Brinda et al., 2014; Brodaty & Donkin, 2009; Gupta et al., 2006; Murphy et al., 1997; Scharlach, 1994). These inequities are perhaps further exacerbated in poor and/or lower caste households in India where dual incomes are often a necessity that makes women's participation in the paid labor force essential for daily living, while maintaining domestic and care giving work as women's work.

#### **4.2 Intimate partner violence (IPV)**

Violence against women in emerging economies has been a rising concern among scholars and policymakers, and intimate partner violence (IPV) appears to be the most common form of violence against women in these settings (Duvvury, Grown, & Redner, 2004). In a nationwide representative survey conducted in 2005-2006 in India, which for the first time included marital violence, 40 percent of women reported having experienced some form of violence from their husbands, and over half of these women indicated that they believed the violence was somehow

warranted. Forty-one percent of women in this study indicated that husband-instigated IPV was warranted if expected gender roles and expectations were not met, or women did not demonstrate characteristics of a “good wife” such as having children and being sexually compliant, providing care giving for family members, and doing household work. Survey questions regarding marital physical violence included questions about slapping, twisting of the arm or pulling of the hair, pushing, shaking, kicking, being dragged, throwing objects at women, and punching with fists or other objects. Sixty-two percent of women reported to have experienced IPV in the first two years of marriage, and 32 percent in the first five years. Moreover, one in three women indicated having been slapped by their husbands (International Institute for Population & Sciences (IIPS) and Macro International, 2007).

The same survey also explored the prevalence of sexual violence within marital relationships and found that over eight percent of women in the 15-49 year old age group and 10 percent overall reported having experienced sexual violence – including, but not limited to, marital rape. Sexual violence was measured with questions about whether women had been forced into performing any sexual acts or having sexual intercourse against their will. Among women who experienced sexual violence within marital relationships, one in seven reported having had physical injuries resulting from episodes of sexual violence (International Institute for Population & Sciences (IIPS) and Macro International, 2007). Interestingly, there is some literature linking covert contraceptive use in India to IPV among women (see Chhabra, Gupte, Mehta, & Shende, 1988; Wilson-Williams, Stephenson, Juvekar, & Andes, 2008). For example, Wilson-Williams et al. (2008), in their study in rural Maharashtra, India found that some of their respondents used hormonal pills and an intra-uterine device (IUD) covertly and expressed that they were at risk for verbal and physical abuse

by their husbands if their covert use was discovered. However, these researchers were unable to ascertain the direction of the causal relationship between IPV and contraceptive use.

Research in India has also demonstrated that only one percent of women report sexual violence from husbands to police (Raj & McDougal, 2014). Marital rape and sexual coercion have historically been unrecognized in Indian criminal and civil law (Chowksey & Srivastava, 2010; Das, 2010). Moreover, Hindu Laws clearly dictate that a wife's duty is to obey her husband and remain under his protection (Agnes, 1992). Rigid gender norms and relations, double-standards regarding expressions of sexuality, and legislation that does not recognize marital rape (Raj & McDougal, 2014) further exacerbate incidences of sexual violence, trauma by survivors of marital rape, and revictimization within marital relationships (Bhat & Ullman, 2014; Chowksey & Srivastava, 2010; Das, 2010). Several organizations such as the National Commission for Women have been making efforts to instigate change in Indian legislation such that it recognizes marital rape as a criminal act (Bhat & Ullman, 2014). It is important to note that IPV includes emotional, psychological, or economic forms of violence (Ahrens, 2006; Campbell, 2008). The national survey conducted in 2005-2006 also addresses issues of emotional violence using marital control exercised by husbands as a proxy measure – for example, survey questions included whether a woman's husband displayed jealousy or angry if she spoke with other men, or had ever accused her of infidelity. Results from this study found that 26 percent of women reported that their husbands displayed jealousy or anger if they spoke to other men, 18 percent were denied control over money, and 16 percent were forbidden from meeting their female friends (International Institute for Population & Sciences (IIPS) and Macro International, 2007).

## **5. The Study of Men and Masculinity in India**

The study of women and their experiences cannot be conducted in isolation from or independently of the study of men and masculinities. Connell & Messerschmidt (2005) emphasize the relational nature of gender and explain that, “patterns of masculinity are socially defined in contradistinction from some model (whether real or imaginary) of femininity” (p. 848). These scholars also highlight that practices of men and women shape the construction of gender for both men and women. They suggest that there is a need to integrate a “holistic understanding of gender hierarchy, recognizing the agency of subordinated groups as much as the power of dominant groups and the mutual conditioning of gender dynamics and other social dynamics” (Connell & Messerschmidt, 2005, p. 848).

There exists a notable body of work on men and masculinity in India, starting with constructions of masculinity in Hinduism and Nationalism in Colonial India (for example, Banerjee, 2005, 2006; Kapila, 2005; Roy, 2002; Sinha, 1999). Research on masculinity and men in modern India focuses on a broad range of topics such as sexuality, health, wellbeing, sexual division of labor, migration, and IPV (for example, Agrawal et al., 2014; Alter, 2011; Chopra, 2006; Duvvury & Nayak, 2003; Osella & Osella, 2000; Staples, 2011; Vera-Sanso, 2000; Verma et al., 2006; R.K. Verma & Mahendra, 2005; Yim & Mahalingam, 2006). One recent report by Nanda et al. (2014) covers a broad range of issues associated with masculinity, IPV, and son preference in India for the purpose of identifying potential ways to engage men as change agents in addressing gender discrimination. This large-scale study, conducted across seven states, also aims to ascertain the multiplicity of masculinities in India, the factors that contribute to them, and the ways in which boys and men - and subsequently girls and women - are impacted. Interestingly, one of the key findings of the study was that men who were perpetrators of IPV were diverse across

age, educational status, place of residence, and caste groups, therefore highlighting the pervasiveness of IPV in the fabric of gender relations in India. However, the researchers also explain that increasing education and economic status among men generally translated into the practice of more equitable gender norms.

An evolving body of work globally has focused on ways to achieve gender equitable practices and norms in societies by engaging boys and men (for example, Barker, Ricardo, & Nascimento, 2007; Connell, 2003; Esplen, 2006; Torres, Goicolea, Edin, & Öhman, 2012). Several of these researchers have focused specifically on engaging men in programs that address gender relations for HIV prevention specifically (Bowleg et al., 2011; Dworkin, Colvin, Hatcher, & Peacock, 2012; Dworkin, Treves-Kagan, & Lippman, 2013; Mills, Beyrer, Birungi, & Dybul, 2012; Pulerwitz, Michaelis, Verma, & Weiss, 2010; Ramirez-Ferrero & Lusti-Narasimhan, 2012). There is also a growing body of scholarship focusing on engaging men for gender equity specifically in India (for example, Khan, Mishra, & Morankar, 2008; Miller et al., 2014; Singh & Ram, 2009; Sinha, Peters, & Bollinger, 2009; Verma et al., 2006). For example, Verma et al. (2006) report successful results from a pilot program conducted among young men from low-income communities in Mumbai, India that addressed norms around gender, sexuality, and masculinity. These researchers found that young men who participated in the program were better able to critically analyze gender dynamics and health risks, and were less supportive of inequitable gender norms and sexual harassment of women and girls after program participation. Another evaluation study by Miller et al. (2014) focused on a prevention program for student cricket athletes in Mumbai, India. This program advocated bystander intervention efforts encouraging men to verbally (and non-violently) stop their peers from participating in abusive or disrespectful behaviors towards women. Evaluation of this program found that there were significant

improvements in gender-equitable attitudes among program participants, and marginally significant improvements in bystander behaviors. Despite the existing programs and literature on masculinity and ways to engage men towards gender equity in India, further efforts are needed from researchers, program planners, and policy makers - particularly among poor and low-caste populations where women are most marginalized and vulnerable to gender-based violence.

## **6. Looking Forward**

One of the key strengths of Connell's integrative theory of gender and power is that it not only attempts to identify the pattern of gendered structural constraints – and how the different components interact – but, in doing so, also encompasses the transformative potential of the restructuring of gender orders within societies (Connell, 1987; Maharaj, 1995). Social theories of gender have traditionally seen gender relations as self-contained and self-reproducing. However, Connell challenges this approach and states that masculine domination and feminine subordination are not self-reproducing, but rather comprise a historical process that is open to challenge, resistance, and change (and in fact needs substantial efforts to maintain) (Connell & Messerschmidt, 2005). She writes,

These [structural] patterns together sustain the overall subordination of women by men.

Identifying the dynamics which have the potential to transform these features amounts then to identifying the conditions for changing in fundamental ways the conditions of future social practice. (Connell, 1987, p. 159)

Understanding avenues of change in gender ordering of societies provides a useful lens to better understand the stages and processes of transformation towards gender equity.

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# **Women's Health and Wellbeing in the Context of Relationships, Families, and the Larger Society: Gender and power in rural Tamil Nadu, India**

## **INTRODUCTION**

Structure and agency are concepts that have long been a cornerstone of social science research and discussion. Agency has been defined as the capacity to act and is enabled or constrained by existing social structures of a given place and time, including social institutions and social relationships (Charrad, 2010). Structure may be defined as “sets of mutually sustaining schemas [transposable rules or procedures] and resources that empower or constrain social action and tend to be reproduced by that social action” (Sewell, 1992, p. 19). Although social scientists have debated the prioritization of structure over agency and vice versa (Bourdieu, 1977; Durkheim, 1966, 1982; Marx & Engels, 1978; Mead, 1967), it is clear that social structures and individual agency are iterative in nature, simultaneously influencing and being influenced by one another. With regard to literature on gender, social structures, and agency, Fraser (1992) expresses a central dilemma feminist theory has grappled with: “*Either* we limit the structural constraints of gender so well that we deny women any agency *or* we portray women's agency so glowingly that the power of subordination evaporates” (p. 17). This paper attempts to explore women's agency in various domains of their lives such as employment, families and households, and intimate partner relationships while keeping in mind the social context in which they live.

Women's empowerment has recently been a central theme in many international development agendas, including in India. Therefore, the literature emerging from this field has emphasized the significance of the social context in shaping the lives of Indian women. Kabeer (2001) and Malhotra & Schuler's (2005) conceptualization of women's empowerment emphasizes increasing women's agency, defined as “women's ability to exercise power by making choices” (Allendorf,

2012, p. 188). Although there has been longstanding scholarly interest in the area of gender inequities in India (Bhattacharya, 2006; Dunn, 1993; Kishor, 1993; Malhotra, Vanneman, & Kishor, 1995; Purkayastha, Subramaniam, Desai, & Bose, 2003; Sundaram & Vanneman, 2008), international development efforts have recently identified particular areas to address such inequities – for instance, maternal and reproductive health, politics, education, economics, and family relations, including experiences of intimate partner violence (IPV) (Allendorf, 2013; Ban & Rao, 2008; Ciotti, 2009; Deomampo, 2013; Ghose & Mullick, 2015; Gupta & Yesudian, 2006; Jejeebhoy, 2000; Malhotra & Schuler, 2005; Rao, Vlassoff, & Sarode, 2014). For instance, Allendorf's (2012) investigation into the role of family relationship quality in determining women's agency in Madhya Pradesh, India concluded that family relationship quality was as influential as other well-studied determinants such as education and employment, and women with higher quality family relationships had more agency. Another study by Gupta & Yesudian (2006), based on a national survey in India, explored socio-spatial disparities for women by analyzing household autonomy, mobility outside of the home, attitude towards gender, and attitude towards domestic violence. These researchers concluded that although on a national level 43 percent of women had high household autonomy, 23 percent had high freedom of mobility, 40 percent had no gender preference attitude, and 43 percent were unaccepting of domestic violence, these results varied significantly across regions. Furthermore, research by Rao, Vlassoff, & Sarode (2014) using data from 28 states in India concluded that economic empowerment, which also varies widely by region, was crucial for promoting positive reproductive health outcomes for rural Indian women.

Muñoz Boudet, Petesch, & Turk (2013), in a study that qualitatively explored gender equality, structures of opportunities and constraints, and empowerment among men and women in twenty low- and middle-income countries including India concluded, "Women's and men's opportunities



and actions are determined as much by social norms – including gender roles and beliefs about their abilities and capacities – as by the conditions of the communities and countries they live in” (p. 2). Studies in India have ascertained that women’s agency is expressed in various areas of their lives. Moreover, these areas are interconnected such that lack of agency in one domain (for example, mobility outside of the home) often impacts agency in another domain (for example, employment outside of the home) (Allendorf, 2012; Gupta & Yesudian, 2006; Rao et al., 2014). Although these types of studies in India have been instrumental to shedding light on the status of women’s power and agency in India across various domains of life, it is important to note that many such studies are primarily based on economic or developmental theories. Yet, this field would greatly benefit from more gender-based theoretical frameworks such as the Theory of Gender & Power by R.W. Connell. Connell’s social analysis of gender provides a framework to understand the organization of gender relations within the context of specific social structures - namely structures of labor, power, and cathexis (Connell, 1987).

In addition, there appears to be a dearth of qualitative analyses in India using Connell’s framework for understanding women’s agency and empowerment within the domains of community, family, and intimate partner relationships. A review of the literature identifies only a few studies in India that have used Connell’s integrative theory on gender and power as a central framework (Agrawal, Bloom, Suchindran, Curtis, & Angeles, 2014; Panchanadeswaran et al., 2007). Panchanadeswaran et al. (2007) use Connell’s framework to investigate the intersection of IPV, sexual negotiation, and HIV/AIDS risk among economically disadvantaged women in southern India. Agrawal et al. (2014) use a gendered power framework to assess couples’ HIV risk in two north Indian states. A close examination of the interconnectedness of domains such as community, family, and intimate partner relationships renders visible the gender regimes – defined

by Connell as “the state of play in gender relations in a given institution” (Connell, 1987, p. 120) - that frame women’s lives. Connell’s work on the gendered nature of social structure provides a useful framework to identify normative and structural constraints women face in rural Tamil Nadu, and is therefore used in this analysis.

### **Theoretical framework**

This paper uses Connell’s integrated theory of gender and power as a framework to explore the normative and structural constraints that limit the ability of poor women in rural Tamil Nadu to take independent action on behalf of their personal health and wellbeing. Connell’s theorization of structure “reflects the experience of being up against something, of limits on freedom; and also the experience of being able to operate by proxy, to produce results one’s own capacities would not allow” (Connell, 1987, p. 92). Social structure, according to Connell, describes constraints operating through a complex interaction of types of powers and through a variety of social institutions. Power comprises a category of interconnected structures of “authority, control and coercion” (Connell, 1987, p. 96) relating to gender including, but not limited to, sexual surveillance and regulation, interpersonal violence against women, and economic hierarchies that relegate women to the lower ranks (Connell, 1987; Maharaj, 1995). Connell’s integrated theory of gender and power identifies three distinct - but intersecting - structures illustrating gendered relationships between women and men: the sexual division of labor, the sexual division of power, and the structure of cathexis. Gender inequities in women’s everyday lives are produced and reproduced through social mechanisms such as unequal opportunities or pay in the domain of work, unequal decision-making power and access to resources within families, and unequal power in intimate relationships (Connell, 1987; Wingood & DiClemente, 2000).

This study utilizes Connell's three major structures of gender relations and attempts to explore the following question: What are some of the normative and structural constraints on married women's ability to attend to their own welfare, health, and personal safety in rural Tamil Nadu, India?

## SEXUAL DIVISION OF LABOR

Connell (1987) defines sexual division of labor as the “allocation of particular types of work to particular categories of people” (p.99), and claims that the nature and organization of that work is gendered. She explains that differential allocation and organization become constraints as well as objects of practice – i.e., rather than a mechanical process of reproduction, there exist underlying processes that, through gendered enactment, sustain existing forms of sexual division of labor. In many societies, women occupy different and unequal work roles in the workforce, and are often unequally compensated for the same or comparable work compared to men (Connell, 1987). Moreover, women are disproportionately burdened with unpaid, if not invisible, work such as child care, care for the elderly and the sick, and household work relative to men. The organization and assignment of both work place and family/domestic roles produce entrenched constraints and gender inequities in domains such as women's earning potential and economic prosperity, social status, and health outcomes (Brinda, Rajkumar, Enemark, Attermann, & Jacob, 2014; Connell, 1987; Dhar, 2012; Murphy et al., 1997; Scharlach, 1994; Wingood & DiClemente, 2000).

## SEXUAL DIVISION OF POWER

Sexual division of power can be defined as “having the power to act or change [towards a desired outcome] or having power over others” (Wingood & DiClemente, 2000, p. 543). For example, intimate partner violence (IPV) against women constitutes a brute manifestation of men's

power over women. Sexual division of power is often legitimized by an idealized form of masculinity. The notion of idealized forms of masculinity is best theorized in Connell's discussion about *hegemonic masculinity* and *emphasized femininity*. Connell's original conceptualization of hegemonic masculinity refers to the "form of masculinity in a given historical and society-wide setting that structures and legitimates hierarchical gender relations between men and women, between masculinity and femininity, and among men" (Messerschmidt, 2012, p. 3). In essence, hegemonic masculinity is created through the production of hierarchical and inequitable relationships between masculinity and femininity, and functions to legitimize and reproduce unequal gender power dynamics (Messerschmidt, 2012). Later formulations of the notion of hegemonic masculinity highlighted that the relationship between hegemonic masculinity, femininity, and non-hegemonic masculinity was not based only on gender; instead the relationships of dominance and subordination were shaped by the intersection of the gender hierarchy with other social hierarchies based on race, class, age, and sexuality. Moreover, the intersections of these hierarchies ought to be understood in the context of national, transnational, and global hierarchies (Connell & Messerschmidt, 2005; Messerschmidt, 2012). Connell (1987) emphasizes that the conceptualization of hegemonic masculinity in the absence of other social hierarchies may both reinforce patriarchal ideologies while also disregarding the existence of non-hegemonic masculinities. In this study, the concept of hegemonic masculinity is useful to understand the circumstances under which intimate partner violence (IPV) may prevail (or even be exacerbated) despite efforts to increase women's empowerment and wellbeing. Moreover, a closer understanding of sexual division of power within a community may render visible the ways in which structural and normative constraints impact women's abilities to have control over the safety and wellbeing of their bodies.

## STRUCTURE OF CATHEXIS

Cathexis is the social structure that organizes and constrains emotional attachments and influences intimate relationships (Connell, 1987). Sexual relationships and desires and reproductive aspirations are shaped by the structure of cathexis, which produces and is reproduced by social norms that legitimize the gendered nature of emotional attachments. Specifically, the structure of cathexis influences social norms that determine how and why men and women practice their sexuality, and the range and types of emotional attachments men and women form (Connell, 1987; Wingood & DiClemente, 2000). For example, norms that value women's chastity or prioritize men's sexual pleasure and desire over women's may reflect aspects of cathexis in a patriarchal society. Common double standards that accept and encourage the fulfillment of men's sexual desires through casual sexual relationships, while framing women's sexual desires as acceptable only in the context of romantic love or aspirations for motherhood represent an example of the gendered structure of cathexis. Understanding the structure of cathexis as it operates within a local gender regime provides meaningful insights into normative constraints that diminish women's desires and needs to care for themselves and make decisions regarding how – and under what circumstances - to use their bodies.

## METHODS

### Study Site

This study was conducted in a mid-sized village in the Thanjavur district of Tamil Nadu, India with a total population of approximately 4000 in 2011 (Directorate of Census Operations, 2011). The village was located approximately 35 kilometers from the closest town of Thanjavur.

## CASTE

Despite the Indian constitution opposing caste-based hierarchy, caste continues to be a key axis along which power is distributed in India. The study site comprised individuals who identified as being primarily from either the Scheduled caste (SC) or Backward caste (BC). The Indian government's categorical definitions of Schedule and Backward castes, and the demarcation of caste-based boundaries among social groups in India, has been a longstanding and ongoing political and social discussion from much before Indian Independence. In contemporary India, Backward caste is broadly identified as: (1) the group of all those who need special treatment from the Government, and (2) a level higher than Scheduled castes and tribes, but nonetheless socially and educationally disadvantaged (Galanter, 1978; Ramaiah, 1992). SC families generally make up the lowest ranked social group in the caste hierarchy, and are usually particularly economically impoverished and socially marginalized. Moreover, SC family homes are generally spatially segregated from homes of other castes, thereby amplifying this group's social exclusion and inhibiting access to necessary public or community services (Kumar & Gupta, 2015; Mohindra, Haddad, & Narayana, 2006; Rao, 2009). The realities of social and structural barriers confronting the SC population were reflected in the study through the provision of caste-based government subsidies (such as cement housing and gas provisions for cooking stoves for SC households), in descriptions of caste relations among community members, and in the spatial organization of the village by caste. Furthermore, many men and women who were SC villagers were employees engaged in manual agricultural labor on land owned by BC community members. However, there was no apparent instance of BC members being employed by SC members in this community. In this study sample, 71 percent of women and 61 percent of men self-identified as BC, and 29 percent of women and 39 percent of men as belonging to the SC community. For comparison, the Census

of India in 2011 found that about 69 percent of villagers at this study site were BC members and 31 percent of villagers were SC members (Directorate of Census Operations, 2011).

## **SPATIAL ORGANIZATION OF FIELD SITE**

The largest and main street runs through the middle of the village dividing it into two distinct neighborhoods – the SC and the BC neighborhoods. The village’s main centers of business such as banks, small grocery stalls and convenience stores, tea and snack stalls, places of religious worship, and ceremonial event halls, were located on the main street. There were two main primary health care facilities in the village – one privately run and the other run by the government - where all health services were offered free of charge. There were also two financial service providers located on the main street of the village; one was a major non-banking financial service provider that had been operating in the village for over seven years and specialized in lending programs for villagers, and the second was a smaller bank providing basic financial services. Public buses that ran from the main town of Thanjavur through the village used the main street, and the bus station was also located on the main street. Moreover, a public train service also had a station on one end of the village connecting the village to Thanjavur and other towns. My ability to freely navigate this site was constrained by my gender and social class, which limited the quantity - and to some extent - shaped the quality of the field notes I was able to collect. For further details on the challenges I encountered and how I navigated the study site, please see Appendix B.

## **Sampling and Data Collection**

The study sample for this analysis comprised 45 community women and 28 community men (25 were spouses of the women in my sample). The eligibility criteria for community women were: over the age of 26 years<sup>1</sup>, currently married, a local resident of the village, and having no

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<sup>1</sup> The sample for this study came from purposive sampling conducted for another study focusing on cervical cancer screening in rural Tamil Nadu. During preliminary research, a health worker from one of my clinic sites informed

history of a hysterectomy. Initial recruitment of community women occurred within the private clinic in the village. Typically, one of the female translators would discreetly approach potential women participants in the waiting room who appeared as though they would be eligible for the study (generally based on perceptions about age). If the woman indicated an interest, the female translator would inform me and I would follow-up with a study screener to assess eligibility, which typically took no more than three minutes. Women were informed immediately about whether they would be eligible for the study. Following this, women would be given a copy of the informed consent form for their review, and asked for their availability to schedule the interview. If potential respondents were unable to read the form themselves, translators read the form to them line-by-line and verbally verified respondents' comprehension of the content. Because in-clinic recruitment primarily yielded BC participants, chain-referral sampling was used as a supplemental procedure later in the study period to increase SC participant recruitment. All male respondents for the study were referred to the research team via participating women, with the exception of three male respondents whose wives were unable to complete the interview process after recruitment. Specifically, at the end of each interview, women respondents were asked if they would be willing to provide their husbands' name and contact information to the research team for the purpose of recruitment. Following this, the male translator attempted to contact the husband and asked if he would be willing to participate in the study, and if so, coordinated logistics for the interview (including reviewing the informed consent form). All interviews with respondents were formal interviews, conducted in a private space to preserve confidentiality.

All data collection for this study was conducted between December 2013 and February 2014 and included a combination of a survey (for basic socio-demographic information),

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me that screening was typically offered to married women over the age of 26 years. As a result, the eligibility criterion for women in the study was limited to women over the age of 26 who had been offered screening services.



qualitative in-depth interviews, and participant observation. The interview guide for the in-depth interviews included topics such as family and couple relationships, circumstances of marriage (love or arranged, circumstances of meeting spouse etc.), sexual experiences and behaviors, gender norms, family, household and paid work responsibilities, family finances and spending decisions, freedom of mobility outside of the home, and knowledge and experiences with seeking care for health issues. The survey and in-depth interviews were conducted in the local Tamil dialect by four translators (three women and one man) who were native speakers and were familiar with the region and the dialect. All interviews with community women were conducted by female translators, whereas interviews with male respondents were conducted by the male translator. I was present for all women's interviews, but men's interviews were conducted solely by the male translator in order to facilitate rapport and open discussions. All translators were trained for four weeks prior to the commencement of data collection. Areas of training included, but were not limited to, qualitative interviewing techniques including neutral probing, how to follow-up on respondents' replies, how to respond to unanticipated replies from respondents, issues of confidentiality and privacy, and familiarization with the theory of gender and power to ensure that translators understood key concepts that guided the interview. I also conducted weekly data checks with all translators to discuss study progress, challenges related to conducting interviews, and best practices to ensure the collection of reliable and comprehensive data. The duration for interviews was between 60 to 75 minutes.

Participants in the study were compensated for their time with Rs. 100 (US\$1.59), which reflects the daily wage offered to women for agricultural labor in local government programs. All sections of the informed consent form were discussed in detail with participants, and their signatures were acquired prior to all data collection. All participants were given a copy of this form

when screened for the study, and therefore, had the opportunity to study it carefully and pose any questions to the interviewer prior to signing. Interviews were audio-recorded and de-identified before simultaneous translation and transcription into English by an external transcription service. Institutional Review Board approval for this study was obtained from both the Columbia University Medical Center and the Apollo Hospitals Educational & Research Foundation in India.

### **Data Analyses**

Descriptive data analyses were conducted using Stata Data Analysis and Statistical Software (Version 9) and qualitative data management and analysis was conducted using NVivo 10 software. Translated interview transcripts and field notes from participant observation were reviewed numerous times to foster familiarity with the data. Thematic analysis was achieved through coding and the major themes reported as results were elicited from the data (Boyatzis, 1998; Braun & Clarke, 2006). Braun & Clarke (2006) state that thematic analysis is “a method for identifying, analyzing and reporting patterns (themes) within data” (p. 79). This method of analysis involved close reviews of the transcripts and field notes to familiarize myself with the data as organized under the headings of the different domains in the interview guide. Interview and field notes data were then coded broadly and a preliminary set of codes based on repetitive patterns in the data were identified that provided insight into the research aims of this study (Braun & Clarke, 2006). This preliminary set of codes was closely studied to identify analytic relationships among codes in order to merge codes together or to generate more than one code from an overarching supercode. Following this process, a final list of codes was generated that was applied to the transcripts, and a list of candidate analytic themes began to emerge. The application of codes ensured that data referring to pertinent context in the interview transcripts and field notes was also included under the relevant codes. A codebook was developed comprising individual codes that

were clearly defined and illustrated with relevant excerpts of interview and field notes data. All four translators and myself independently applied the final coding framework, by consulting the codebook, and then discussed in detail areas of consensus and disagreements. All disagreements in the coding framework were carefully considered and resolved with further discussion substantiated by the data. Respondent quotes in this paper have been minimally edited for readability as necessary.

## **RESULTS**

### **Study Participants**

As mentioned earlier, the study sample comprised 45 women and 28 men in the village. The age of women participants ranged from 26 to 52 years with a median age of 37 years, and the age of men participants ranged from 32 to 67 years with a median age of 44 years. Almost all women and men had some level of education, with the majority of women having primary or middle school-level education and a median of 7.5 years in school, and men having middle or high school-level education and a median of 10 years in school. All participants were currently married (as per the eligibility criteria for the study) and cohabiting with their spouse. Eighty-four percent of women participants and 93 percent of men participants were currently employed in either family businesses (for example, running a small convenience store or tea stall or agricultural/farming labor on family property) or in the irregular/casual agricultural labor market working on property owned by others. The reported monthly individual income for employed women participants ranged from Rs. 300 to 12000 (US\$ 4.72 to 188.75), and the median monthly income was Rs. 2000 (US\$ 31.46). Reported monthly individual income among employed men in the sample ranged from Rs. 4800 to 40000 (US\$ 72.69 to 605.78), with a median monthly income of Rs. 8000 (US\$ 121.16). For reference, monthly individual income of community members between the ages of

18 and 60 years in this village has been found to be Rs. 6495 (US\$ 101.80) and the average monthly household income is Rs. 18041 (US\$ 282.78). Moreover, the average monthly income among men in the village has been found to be Rs. 8509 (US\$ 133.37) and Rs. 4457 among women (US\$ 69.86) (data from personal communication with the CFO of a major financial services provider operating in the village<sup>2</sup>). The age at marriage ranged from 16 to 27 years with the median being 19 years for women participants, and from 20 to 39 years with the median being 25 for men participants. The total number of children ranged from 0 to 4 with a median of 2 for women and men. Thirty-three percent of women participants (n=15) lived in joint family households, with the remaining living in nuclear households. Almost 30 percent of men (n=8) in the sample lived in joint family households. Joint families are a classic Indian institution consisting of households with older parents, sons, and son's wives and children. Furthermore, joint families in India almost always comprise wives living with their in-laws rather than vice versa, and typically have the father-in-law or son as the head of the family (Mandelbaum, 1948). All respondents in this study were from Hindu origins. Additionally, 15 percent of women and 18 percent of men in this study reported having had a love marriage - i.e., participants chose their spouse on their own rather than having their family choose the spouse for them (which would have been an arranged marriage).

Sample descriptive data in this study revealed that men were older than their wives across the study sample. Men had also received more formal education and earned higher incomes than women, therefore reinforcing gender stratification. Furthermore, the vast majority of men and women had had arranged marriages, and women were on average married at a much younger age than men, further perpetuating gender hierarchies.

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<sup>2</sup> This data is from a proprietary database of a major financial services provider located and operating in the village for over seven years. The data was provided to me by the CFO of the entity and is up to date as of July 2015.

The majority of SC women participants in this study were recruited via chain-referral sampling rather than in-clinic recruitment. During the data collection period, the majority of women who visited the free private clinic were from the BC community. However, descriptive survey data revealed that the majority of SC participants from the sample, despite having to be recruited via chain-referral sampling, had visited one of the two clinics within the last six months (n=11). Additionally, although instances of inter-caste marriage (SC man or woman married to a BC woman or man) did occur based on respondents' accounts, none of the respondents in this study reported having a spouse from a different caste.

## **Themes**

This study identified three major themes that intersect in complex ways to constrain women's overall health and wellbeing: 1. Women's paid and unpaid work and health prioritization, 2. Power and control over women's bodies, and 3. Gender norms and sexual ideologies.

### **1. Women's paid and unpaid work and health prioritization**

A large number of women in this study reported having some current form of employment. Moreover, among the 67 percent of women in the study living in nuclear households, 70 percent had access to and control over all family finances. All women in the study also indicated that they were responsible for housework and child and/or elderly care within their own households, and received limited help from other family members – especially men.

#### **A. Women's employment and control over family finances**

Although almost all women in the study reported being responsible for all household and care taking-related work - many needing to balance these responsibilities with paid work outside of the home - there were noteworthy differences between the experiences of SC and BC women. SC women were more likely to be part of consistently dual-income households and engage in paid

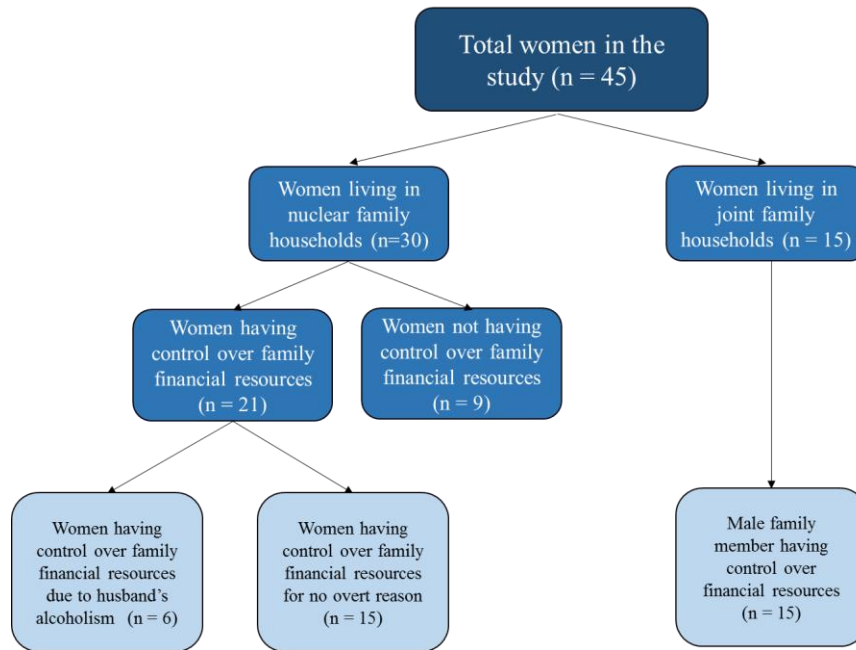
work regularly, whereas BC women generally engaged in agricultural labor on an ad-hoc basis, thereby reflecting the overall socioeconomic disparities of SC and BC communities. Data from this study demonstrated that among women respondents engaged in casual agricultural labor, SC women typically reported working 3 to 4 days a week as compared to BC women who generally reported working 1 or 2 days a week. SC women who regularly worked in the fields during the day were also responsible for housework in the mornings and evenings like other women in this study.

Eighty four percent (n=38) of women in this study reported being currently employed in some form of work that was outside the scope of child care and house work. Among these women, approximately 60 per cent (n=23) reported being engaged in casual agricultural labor on land owned by others, 29 percent (n=11) in agricultural or farming labor (related to cows, goats, or chickens) on their own family's land, and 11 percent (n=4) in non-agricultural work on the main street such as operating a tea stall with snacks, running a small convenience stall, working in a bank, and cooking in the village school's cafeteria for students and staff. Agricultural labor was reported to be the most physically taxing work, with less consistency as it was largely dependent on women's physical health and ability to work. All respondents who reported non-agricultural work were from the BC community. Non-agricultural labor, particularly employment in banking or financial services, health facilities, or even grocery stalls, was considered to be less "blue-collar" and held in higher regard compared to agricultural labor in this community. This was evident from participant observation data that revealed that individuals in these jobs, men or women, were often treated with deference by community members and would be referred to as "Sir" or "Madam" (or *amma* and *anna* which translate to "mother" or "big brother"). However, many of these jobs were

located on the main street of the village and there were few women (as compared to men) that held these jobs (see upcoming section on women's mobility in public spaces for more details).

A little less than half the women in the study indicated being the primary managers of money in their households – i.e., women stored and managed their own earnings and their husbands' earnings. Family structure was key to women's control over, access to, or management of financial resources within the family. Among women who were living in nuclear family households, 70 percent had control over financial resources; among these women almost 29 percent reported that they had taken over monetary control within the family because their husbands' alcoholism had rendered them financially irresponsible. As one 45 year old BC respondent explained, "He is always drinking and while he is drunk most of the time he would not be able to manage the family...I cannot depend on him ... even if he has little money he would drink with it." The remaining 71 percent of women respondents from nuclear families having control over family finances did so for no overt reason (as compared to women who controlled family finances because of their husbands' alcoholism). All women who were in joint families (~33 percent of the overall sample) reported having no control over financial resources – i.e., financial resources were managed by their husbands, fathers-in-law, or, in some rare cases, brothers-in-law. The subgroups within this sample based on control over family monetary resources have been detailed in Fig. 1.

Figure 1. Women's control over financial resources within the family



## B. Women's prioritization of paid and unpaid work over health

Women's accounts of having to prioritize paid or unpaid work (for example, housework, or child or elderly care) over their health needs was a common finding in this study. Interview data from women demonstrated that women were burdened with labor both within and outside of the household, particularly among SC and/or very low income households where women had no choice but to engage in paid work in order to support the family. One SC respondent described how she navigated competing priorities related to her own health and her family's monetary and non-monetary needs. She clarified,

I go to work even if I had fever because I have to [earn in order to] feed my family. Because of my financial position I have to go to work to support the family. So, I just eat a tablet and go to work. Sometimes I would go to work without having food. It was okay, as I would forget about my health once involved in the work. (40 year old, SC respondent)



When asked why she was unable to seek care from a doctor when ill, this respondent explained that it was primarily because of the lack of money and the need to go to work. She also stated that at times she felt too weak to walk to the hospital and was concerned she would faint on the way to the facility. Moreover, this respondent stated that she would be unable to seek care if her children were in the midst of school examinations because she needed to care for them and help them prepare. She clarified that if her husband was at home, then he would assist her to the doctor but otherwise she would not be able to seek health care when needed.

During interviews, women were also asked what a typical day of housework comprised. A 37 year old BC respondent elucidated,

I wash my face after I woke up, then would dilute the cow dung, make hot water for my children, would fetch the water, prepare the food for the boxes and for my husband as well, then clean the house & vessels...Yes, it would be tiring and would feel like taking rest...I ignore the tiredness. (37 year old, BC respondent)

This respondent highlights that although she feels as though she needs rest from tiring and extensive housework, she ignores the need to let her body rest. Similar to this respondent, most women indicated that they woke up at around 4am, fetched water for bathing, cleaned kitchenware, cooked, and then heated water for their children and husbands to bathe with. Following this, some women left for agricultural labor by 6am, while others remained at home. Women engaging in agricultural field work returned to their homes by 4pm, after which they would begin to cook dinner and feed their children. Women would join their husbands for dinner later in the evening, and turn in for the night by about 11pm. These accounts of women's long work days, feelings of tiredness, and inability to attend to their own body's need for rest or necessary medical care provides a representative example of both SC and BC women's competing priorities and the

inability to prioritize their own health and wellbeing needs amidst various financial and familial responsibilities and constraints. Moreover, the tensions around managing responsibilities related to paid work in conjunction with housework were more exaggerated among SC women due to their overall lower socioeconomic status, which rendered their wages essential to the family's survival.

### **C. Women's experiences of lack of help and support from family members regarding housework**

In most cases, women reported that they took care of almost all domestic labor for the family and household. Women who had older children – especially daughters – generally received some help with housework once the children returned from school in the afternoon. In joint families, housework was typically shared among the women in the family, although there were some exceptions where one woman (typically the daughter-in-law) assumed all household responsibilities. It appeared as though women who had younger children (or no daughters) found it most challenging to receive help with housework.

Women often reported carrying water into the house and washing clothes as the most difficult chores, and some women reported that their husbands or sons would help with carrying water into the house. In a limited number of cases, men washed their own clothes and the women washed their own as well as the children's clothes. In general, all cooking and cleaning work was conducted by women in the household. Although some men did help with minor household chores at times – especially if women were traveling or very ill – housework appeared to be predominantly women's work. Many women expressed that if they were too ill to cook, their husbands would buy food from outside but they would not assist with cleaning or other household chores. A 33 year old BC woman respondent noted,

[Husband] has not helped me in anything. Even if I am bedridden he would not do all that, that's his character so I would not expect all that, even if I go to my home town for visit everything will be the same as how I have kept when I left... We have to think that's all that we can expect from him and leave it. (33 year old, BC respondent)

Interview data from both men and women in this study suggested that housework was overwhelmingly women's work, regardless of age, caste, family type (joint or nuclear), or age at marriage. Moreover, if women fell ill, in the majority of cases housework was stalled (while accumulating over time, in many cases) until the time women had recovered from their illness. In many instances, women were not only responsible for housework and paid work, but also for caretaking of children and the elderly – especially among study respondents who resided in joint families with their husbands' parents and/or brothers and their families. In cases where women's already busy days were further burdened with caretaking of younger children or the elderly, some women expressed not receiving any help with the work despite the added responsibilities of caretaking. As one respondent living in a joint family with her in-laws articulated,

Keeps telling that [mother-in-law] is not feeling well and doesn't do house work at all. I do work in house, out of house, and also for children work. If mother-in-law and father-in-law need, I do work at home and take to doctor. Father-in-law is being sick nowadays. But mother-in-law just [falsely claims to be sick all the time]. (31 year old, SC respondent)

This respondent not only highlighted the multiplicity of work roles she is expected to handle, but also pointed to the disadvantaged position of being the younger woman in the household – i.e., her mother-in-law used illness as an excuse to refrain from helping with housework or caretaking in the family, therefore leaving her solely responsible for these duties.

## **2. Power and control over women's bodies**

### **A. Women's restricted mobility in public spaces**

In general, women and men in the study appeared to have a mutual understanding about informing their spouses if they left the house. In instances when women or their husbands were unable to directly inform each other, they would often ask neighbors or other family members to inform their spouse. Although women were not overtly restricted from leaving their homes, the main street in the village where most businesses and services were located was a highly gendered space. The gendered division of labor was clearly reflected in public spaces, with men having more access to and occupying the more active business spaces of the village, whereas women were primarily constrained to the inner residential streets or agricultural fields located away from the main street. In general, paid work roles on the main street were more often designated to men as compared to women. There was a tacit agreement among men and women in the village that the main street was not a place for women to loiter, but only to use for necessary errands. This was particularly the case early in the mornings or after 4pm when men returned from agricultural labor and socialized with other men on the main street. Socializing among men generally entailed drinking tea or alcohol and/or smoking and discussing or arguing among friends about community happenings, politics, or work-related events. Social norms in the village dictated that it was inappropriate for women to be present on the main street, especially after men came back from the fields. Furthermore, gender norms in this community indicated that women should not interact unnecessarily with men who were not related to them. In their interviews, women alluded to the reputational and sexual risk inherent in male-dominated spaces such as the main street. Field notes from participant observation also support the claim that the main street was male-dominated:

5pm: There are no women or children on the main road, as is consistent with other evenings. This afternoon, there were a few women who appeared to be running errands,

[community health worker] who left for lunch and came back, and a few other women who appeared to make stops at the clinic or at the bank. There were also some women who came out of the school and were talking to other women they saw inside the bank. There was the usual throng of school children walking home in large groups after school ended around 3pm. But in the evening, the road is occupied only by men. They are sitting or standing in groups, dispersed all over the main road – sometimes right in the middle but often on the margins of the road by the buildings. Most are smoking, some are drinking a beverage (sometimes tea, other times something indecipherable). Many of the men are talking loudly. There is a lot of loud laughing, “story-telling” – all communication appears to be loud with men often talking over each other. (*Excerpt from field notes*)

The gendered nature of the main street space in the village was also corroborated by both women and men respondents during interviews. For example, one woman study respondent explained,

Ladies ourselves won't go. This is a habit in most of the villages. Won't go out in the early mornings even to the next vegetable shop, because men would be there and crowded... The shops are in the main road and men would be wandering around that place. So we avoid going in the mornings and evenings. In evenings, men drink alcohol there so we don't go.  
(51 year old, BC respondent)

Another 55 year old SC male respondent in the study clarified, “Ladies will be inside the house but men will drink and pass their time. For [formal community social events] ladies will come out, else they don't. They don't roam out like men unnecessarily.” These findings highlight that the main street, which was also the most public and active space in the village, was primarily a male space. The gendered nature of this space was an implicit community norm, and one that most women abided by. Moreover, although the space was less gendered in the middle of the day and it was more acceptable for women to be present, women still restricted their use of the space to when it was necessary - i.e., women did not spend idle time socializing on the main street as men did. As a result, women's participation in the public spheres was limited both formally and informally via social norms as well as gendered structures of paid work in the village.

## **B. Constrained control over family planning**

Family planning was available free of cost to all respondents in the government health facility located in the village. Although some women in the study had discussed family planning with their husbands and had made consensual decisions with them, 20 percent of women in the study reported having taken measures for family planning without informing their husbands. These measures included either surgical sterilization or use of the “copper T” method (IUD). Age, caste, family type (joint or nuclear), or age at marriage did not appear to influence whether women covertly used these measures for family planning. Women typically cited wanting to mitigate additional caretaking or financial burdens associated with having more children as reasons for covert use. One study respondent stated that she wanted family planning so she could better manage her existing responsibilities, but her husband would not allow family planning due to concerns about side effects. She explained,

Because of the [housework], I decided to stop after 2 children. I had copper-T without telling my husband. Otherwise, he would tell me not to use copper-T...pregnancy would give lot of troubles like vomiting, dizziness etc., which I definitely would not be able to manage. I had no time to look after anything other than my household work. So, I stopped with 2 children. (51 year old, BC respondent)

In addition to concerns about being overburdened by housework, this respondent also emphasized her concerns about the impact of pregnancy on her health and ability to carry out her existing household responsibilities. Another 35 year old BC respondent elucidated that she had the IUD inserted after her second child without telling her husband, but had experienced adverse side effects from the device. After discontinuing IUD use, she had two unplanned pregnancies. After

her fourth child, this woman underwent sterilization without her husband's knowledge. When asked if her husband had ever considered abortion after the unplanned pregnancies, she stated,

Never. He always forced [me] to continue the pregnancy. In our tradition if we are pregnant we have to deliver it. Can't abort it, because it's sin. So I myself went for family planning operation without telling him. (35 year old, BC respondent)

In general, it appeared as though women's decisions to covertly use family planning methods were influenced primarily by existing family and household responsibilities and the burden of unplanned pregnancies, both from the women's health as well as financial perspectives.

### **C. Normalization and tolerance of IPV**

Almost two-thirds of women in the study reported past or current episodes of intimate partner violence (IPV). IPV was often spoken in conjunction with husbands' alcoholism – i.e., when asked if they had ever experienced violence from their husbands, many women reported that their husbands beat them or engaged in sexual violence while they were drunk. None of the respondents indicated that IPV was something to seek health care or legal recourse for. Women in this study spoke about IPV both in the abstract (as events that happen in general) and in specific (by their own husbands). However, they did not provide any indication of how severe physical altercations and outcomes were. In contrast, women's accounts of sexual violence were often described to be severe in nature. Overall, interview data suggested that IPV was largely normalized and tolerated in this community, thereby highlighting a major constraint on married women's ability to maintain their health and personal safety in this community.

#### *Physical violence*

Women most frequently reported financial problems, family issues (typically with the extended family), or excessive alcohol consumption by their husbands as reasons for violent fights

within the couple. Both men and women often spoke of IPV in the context of the husbands' excessive drinking. A 45 year old BC woman explained that her fights with her husband occurred once or twice a week and were always violent with him beating her. She recounted that their kids and the neighbors would attempt to stop the fights by getting in between the couple and separating them. She explained, "I would hold his hand and abuse him in bad words. Then my husband would get [angrier] and come to beat me. The only reason for the fight is drinking, other than that he is a very good person." All but one study respondent claimed to never have hit their husbands - either by instigating a fight, defending themselves against their husbands, or in retaliation. Therefore, IPV instigated by men was highly normalized in this community, and it appeared that social norms dictated that women should never be violent towards their husbands – even in defense of their own bodies.

A number of men in the study reported having displayed physical violence towards their wives. Interestingly, men's interviews revealed that there were instances where women left their homes for months and stayed with their own mothers after a display of physical violence from their husbands. An SC man expressed that he had fought with and beat his wife after drinking for over a year during their marriage. Following this, he reported that his wife left their home for five months. He stated,

I beaten her and pushed her out of my house. Suddenly, my uncle visited here for some reason. He took her in the car and gone to his home...After staying [at my uncle's house] for 20 to 30 days, she went to my mother-in-law's house. My sister only brought her back. She convinced her. (43 year old, SC respondent)



It is noteworthy that, in this respondent's case, the male respondent's own uncle not only helped the respondent's wife leave her home but also housed her in his own home for almost one month before she went to stay with her mother.

In several instances, men expressed that they did not feel as though they had to convince their wives to come back to their homes. A 48 year old BC respondent stated that he and his wife frequently got into violent fights where he would slap her face. He further stated that at times his wife would leave their house and stay with her mother, who lived close by, for anywhere between two to four months at a time. He clarified,

There are lots of times, when she has gone to her mother's place, I have hit her, but not once, did I go and bring her back. Either my sister or mother would bring her back...I don't do that. Just because I had hit her, why should I bring her back? I will be stubborn and have the conviction that I should not go. (48 year old, BC respondent)

In instances of IPV among couples, it appeared as though women sought time away from their husbands by staying with other family members, usually their own mothers. Additionally, findings suggest that fights were generally resolved with family members - often women - acting as mediators in the aftermath of a fight and convincing women to return to their homes.

### *Sexual violence*

Some instances of IPV among women in the study included forced sex after excessive alcohol consumption by men. Here again, sexual violence – although not as overwhelmingly normalized as physical violence – appeared to be accepted to the extent that women did not report seeking any type of mental or physical care or any legal recourse. A BC respondent described,

If he is drunk and I refuse sex he would get very worked up and abuse me. If he is still in his senses I would comply but if he is too drunk then I would avoid sex. When he is not in

his senses he would become too violent during sex...It would be awful. I would wish I was dead. (31 year old, BC respondent)

Another 29 year old BC woman described how sexual activity was particularly difficult for her when she was experiencing excessive vaginal discharge and pain, presumably due to an infection. She stated that sometimes her husband would force her to have sex despite her discomfort and pain:

If I have pain, he forces me for sex due to which we fight. He won't beat me but forces me and wins, and I will leave him thinking that he is a man. I told him it pains more when I have pain already but if he does not listen to me, what can I do then? (29 year old, BC respondent)

These quotes demonstrate the extent to which some women in this community experienced sexual violence from their husbands, and moreover, seem to accept it as part of the marital relationship. It is important to note that although numerous men in the study reported being perpetrators of physical violence towards their wives, none of the men acknowledged sexual violence in the interviews. In general, men stated that they asked their wives to have sex, and their wives generally complied - even in cases of initial hesitance.

### **3. Gender norms and sexual ideologies**

#### **A. Ideologies regarding spousal characteristics**

Men and women in the study were asked to list what makes a good wife or a good husband (see Table 1.). Both men's and women's descriptions of a good wife were more detailed than descriptions of a good husband.

Table 1. Characteristics comprising a good wife and a good husband from study respondents

	Women's responses	Men's responses
Characteristics of a good wife	<ul style="list-style-type: none"> <li>• Good maintenance of the household</li> <li>• Cooks whatever the family desires</li> <li>• Does not gossip</li> <li>• Maintains good relations with family and community members</li> </ul>	<ul style="list-style-type: none"> <li>• Good maintenance of the household</li> <li>• Cooks well</li> <li>• Takes good care of the children, husband, and elderly</li> <li>• Spends money carefully</li> <li>• Maintains good relations with family and community members</li> <li>• Is affectionate</li> </ul>
Characteristics of a good husband	<ul style="list-style-type: none"> <li>• Works hard and takes care of the family</li> <li>• Is affectionate</li> <li>• Has no bad habits such as drinking, smoking, or gambling</li> </ul>	<ul style="list-style-type: none"> <li>• Works hard and takes care of the family</li> <li>• Has no bad habits such as drinking, smoking, or gambling</li> </ul>

In general, characteristics associated with women's roles were more domestic and family-centric as compared to men's. Extending beyond the family domain, both men and women stated the development and maintenance of good relations with everyone in the family and community as a characteristic of a good wife, but made no mention of this characteristic for a good husband. Many men and women identified having no "bad habits" such as drinking, smoking, or gambling as an important trait in good husbands. Interestingly, neither men nor women mentioned being non-violent as an important trait in a good spouse despite the high prevalence of IPV reported by women respondents. This appears to be another indication of the normalization of IPV in this community. Moreover, women's income earning capacity appeared to be missing from the characteristics of a good wife despite the fact that women from both castes described working outside of the home. Neither men nor women described good wife characteristics to include women taking care of their wellbeing or being healthy and happy. Finally, whereas numerous men

specified a good wife as one who would take good care of the husband and children, women generally described a good husband as one who would take care of the overall family rather than the wife specifically.

## **B. Ideologies regarding sexuality**

Women respondents spoke of sexual desire and sexual activity in two major ways: 1. Men's biological imperative for frequent sex, and 2. Their fear of accusations of infidelity. One 37 year old SC woman explained that the presence of her children in the household made her uncomfortable and decreased her desire to have sex. She expressed, "Being a man he would not be so much aware of children's presence...I would be wary of presence of the kids in the house. It would make me very conscious. Men cannot go without sex for long and hence I comply." Several other respondents in this study also emphasized that men's sexual desire was more frequent, persistent, and moreover, a biological imperative, unlike women's.

For a number of women respondents, positively responding to men's sexual desires were commonly associated with mitigating accusations of infidelity. Moreover, some women expressed that the role of a wife was to be compliant to her husband's sexual desires. The fear of accusations of infidelity among women appeared to be an extension of the belief that sex was a biological imperative for men and, therefore, women must subordinate their desires to those of their husbands. A 37 year old BC woman, when asked if her husband had ever forced sex upon her, responded, "No, he won't and I also won't make him go to that extent either...That's why I'm there as a wife, isn't it? Otherwise, he would doubt me." Another 36 year old BC respondent explained that sexual satisfaction of the husband was key to a happy family: "The girl should satisfy her husband whenever he calls. Only then there won't be any fights or arguments within

the family. If not, he then would doubt his wife that she might have some affair.” One study respondent described arguments with her husband when she refused him sex. She elucidated,

He would get annoyed when I refuse to get intimate. He would accuse me that I am cheating on him. I would get angry and tell him that I am loyal to him. He would then reason why I was not complying to his sexual demands. In the end, I would comply so as to make peace.

(31 year old, BC respondent)

This respondent indicated that accusations of infidelity by her husband, followed by her desire to end the argument, led her to be compliant with her husband’s sexual desires. The concerns about being accused of infidelity by men and wanting to abate these accusations was a recurring theme among women in this study.

## **DISCUSSION**

Findings from this study provide valuable insights into how the local gender regime impacts women’s abilities to secure their personal good health, safety, and wellbeing in this community in rural Tamil Nadu, India. I hypothesize that sources of variation in women’s agency to achieve personal health and wellbeing include caste, social class, household structure (nuclear versus joint), marriage type (arranged versus love), and husband’s alcoholism or lack thereof. However, this study had insufficient data to test these hypotheses.

Extensive scholarly attention has been paid to women’s work around the world: formal and informal work participation, paid and unpaid labor, and public and private spheres of work for women. There has also been an emphasis on how women’s experiences of the “double day” or the “second shift” impacts and constrains their wellbeing – i.e., how being engaged in demanding employment in addition to their roles of housework and child care burdens women’s lives and health (Nussbaum, 2000, Hochschild & Machung 1989). Findings from this study demonstrated

that housework was primarily women's responsibility, even in families where women engaged in paid work outside of the home. Women also highlighted that they received limited to no help from other family members in these duties, even when they were ill.

Research on caregiving within families demonstrates that gender stereotypes legitimized and reproduced by deeply rooted gender inequalities ensure that women are disproportionately burdened with caregiving duties within families (del-Pino-Casado, Frías-Osuna, Palomino-Moral, & Ramón Martínez-Riera, 2012; Gerstel, 2004; Miller & Cafasso, 1992). Rubin & White-Means (2009) have coined the term “sandwich caregivers”, defined as “persons with both aging parents or in-laws and children under the age of 18” (p. 254) to refer to the doubled caregiving of the young and elderly. Informal care – i.e., unpaid voluntary care given by family or friends – for the elderly is typically long-term in nature and women comprise the majority of informal caregivers, both in India and in other countries (Shaji & Reddy, 2012). In a study by Dhar (2012) exploring caregiving for the elderly within families in India, respondents indicated that the multiple roles of the caregiver – child care, paid laborer, and family and household obligations – were often conflicting and kept them busy for the entire day, therefore causing mental and physical fatigue on an ongoing basis. These findings are similar to findings from the present study where women detailed their multiple responsibilities in a typical day and expressed their feelings of being chronically tired and neglecting their own health. Caregivers facing the multiplicity and conflicting nature of work roles have been described as “conflicted workers” – i.e., workers who struggle to maintain their various work roles while also dealing with adverse effects of caregiving (Murphy et al., 1997; Scharlach, 1994) such as poor physical health, anxiety, and depression (Brinda et al., 2014; Brodaty & Donkin, 2009; Gupta, Punetha, & Diwan, 2006; Murphy et al., 1997; Scharlach, 1994).

Moreover, findings that SC women were more likely to be burdened with household chores as well as paid work outside of the home as compared to their BC counterparts corroborates other recent research in India (Barker, Chorghade, Crozier, Leary, & Fall, 2006; Rahman & Rao, 2004; Srivastava & Srivastava, 2010). These studies have demonstrated that workforce participation rates were highest for SC women as compared to women from higher castes - largely because women from lower caste groups came from impoverished households and had no choice but to engage in paid work. Other scholarly work focusing on gender and caste discourses about SC women in India (specifically the compilation of writings by Rao (2005)) highlights the particular ways in which caste and class combined with gender push SC women to the outermost margins of the political economy in India as compared to men or women of higher castes (Malik, 2005). Therefore, although the specific comparison of health outcomes between SC and BC women was not assessed in the present study, it is possible to speculate that SC women in this community, as an aggregate, may experience poorer health outcomes due to their many persistent work roles. Nevertheless, there is a need for further research on the gendered division of labor within households and families in India to better design interventions aimed at engaging men in housework and caregiving, therefore easing women's double shift burdens. Such interventions, for example, may aim to create gender sensitization about women's work roles, bring awareness to the adverse health and family effects of overburdening women with multiple work roles, and create pathways to engage men in sharing household and caregiving responsibilities.

The meanings and interactions within public spaces have been of longstanding interest to numerous researchers. For example, Erving Goffman has written extensively on the meaning of social interactions in public spaces, including the concept of "civil inattention" that enables individuals to let other individuals (who are strangers) to occupy and conduct their business in

public spaces (Goffman, 1963, 1971). However, despite the richness of Goffman's work on public spaces and social interactions, it does not assess gender as a central social category in public spaces as Gardner (1989) demonstrates in her research in a small city in New Mexico, US. The gendered nature of public and private spaces has been discussed extensively in literature related to gender and sexuality studies both in and outside of India. In their multi-site research on marriage and HIV-risk, Hirsch et al. (2009) describe in detail the relationship between gender norms, spatial boundaries, and sexual and reputational risk. Similar to the main street in the present study, the authors explain that certain spaces where male socialization occurs are understood to be spaces where proper women do not enter. Therefore, women who place themselves in such spaces risk damaging their reputation as virtuous women (Hirsch et al., 2009). Additionally, research by Ali (2012) has explored how working class women negotiate social vulnerability and sexually threatening public spaces in Karachi, Pakistan, and Little, Panelli, & Kraack (2005) have studied rural public spaces and women's fear of crime in New Zealand and the UK.

Women's restricted mobility through gendered public spaces is also reflected in a vast body of literature pertaining to India. This work has explored ways in which spatial dimensions influence women's mobility across designated physical and social spaces, and in turn, reproduce women's subordinate status in these spaces (Devika & Thampi, 2011; Dube, 2005; Kantor, 2002; Niranjana, 2001). Dube (2005) points to links between the social control of women's mobility and bodies in relation to maintaining the purity of caste – i.e., the “management of female sexuality in a caste society” (p. 234). This scholar postulates that the cultural anxiety of sexual relations among individuals of lower and higher castes, and the possibility of mixed-caste “impure” children, plays a notable role in how women's lives and bodies are shaped, controlled, and restricted through their lifetimes. She states,



Caste thus imparts a special character to the process of growing up as a female... Women need to be controlled, their sexuality contained, at all times. This is sought to be achieved through mechanisms of proper social control, idealization of familial roles, and an emphasis on female modesty. (Dube, 2005, p. 234).

Other research conducted by Bose (2007) in low-income settlements in Kolkata, India highlights how restrictions on women's mobility in public spaces intersect with the types of paid work that are accessible to women. Resonant with findings from the present study that display limited formal paid work for women on the main street, Bose (2007) posited that social norms limiting women's spatial mobility in her research sites decreased job options and pushed women towards low paid home-centered work such as garment stitching, food processing, or *beedi* (cigarette) rolling, to list a few. The scholar concludes that this type of spatially restrictive home-centered work was also the least compensated and offered almost no opportunities for women's empowerment. In the present study, women's paid work was overwhelmingly either casual agricultural labor on other people's land or agricultural and farming labor on family land, as compared to the more "white collar" jobs on the main street that were disproportionately occupied by men. Moreover, women reported agricultural work to be physically taxing, especially in addition to the physical work associated with their household responsibilities.

This study also revealed that household structure tends to play a substantial role in access to and control over family financial resources for women – i.e., all women who had control over family finances in this study were from nuclear households and none of the women in joint family households had control over family finances. This could perhaps be due to the fact that joint families have the presence of multiple men (more than just the husband), which may activate patriarchy in ways that prevent women from having control over family finances. Microfinance

schemes and self-help groups in India have worked extensively to not only empower women from an economic standpoint, but to also engage them in activities related to public participation in the community and stable employment opportunities, thereby crossing boundaries of gendered spaces in communities (Nussbaum, 2011; Sengupta, 2013; Singh & Cready, 2015). However, as evidenced by findings in the present study and other studies mentioned previously (including Kabeer, 2005), development and intervention work related to increasing women's mobility in public spaces and providing access to stable, rather than casual and low-paid, work is far from complete - especially in rural India. Moreover, it appears as though special attention must be paid to women residing in joint family households as they are likely to face different, if not additional, constraints to economic agency and wellbeing.

At 20 percent, there was a substantial proportion of women in this study that indicated covert use of family planning methods, i.e., women's use of family planning without their husband's knowledge. It is important to note that although women in this study were challenging the existing gender regime by using contraception covertly to attain their personal reproductive goals and wellbeing, by hiding their use of contraception they were also reproducing the gendered discourse about women's decision-making power and choice regarding their reproductive behavior. The process of and tension with constrained agency and resistance has been discussed in Manuel Castells' work on constructions of identities related to oppression, stigmatization, and resistance. Castells (2009) defines *resistance identities* as,

generated by those actors that are in positions/conditions devalued and/or stigmatized by the logic of domination, thus building trenches of resistance and survival on the basis of principles different from, or opposed to, those permeating the institutions of society. (p.8)

Women in this study demonstrated inhabiting resistance identities with the covert use of contraception in the face of male dominated ideologies and decision-making powers about family planning. Castells' notions of "trenches of resistance and survival" are particularly salient in the context of women making family planning decisions that go against their husbands' wishes - to both balance their existing familial and household obligations, and to protect their health and wellbeing. However, Castells also identifies *project identities* in his work, defined as:

when social actors, on the basis of whatever cultural materials are available to them, build a new identity that redefines their position in society, and by so doing, seek the transformation of overall social structure. (Castells, 2009, p. 8)

It appears as though some women in this study who reported being able to make consensual family planning decisions with their husbands had come closer to attaining identities akin to project identities, but these identities were still inaccessible to those women who felt they had to use contraception covertly. Therefore, these women were still engaging with resistance identities in order to exert some control and power over their reproductive desires, bodies, and health outcomes.

A substantial body of scholarly work has examined women's covert use of contraception both within and outside of India (Biddlecom & Fapohunda, 1998; Castle, Konate, Ulin, & Martin, 1999; Grabbe et al., 2009; Sargent, 2005; Stephenson, Jadhav, & Hindin, 2012; Wilson-Williams, Stephenson, Juvekar, & Andes, 2008). Some research on covert family planning (including abortions) in India has identified and studied the links between IPV and covert contraceptive use (for example, Wilson-Williams et al., 2008, Chhabra et al. 1988). In the present study, respondents typically cited wanting to better manage existing family and household obligations, avoid unwanted pregnancies, and maintain their health as reasons for covert use. However, given the existing literature linking IPV with covert contraceptive use, and the extensive occurrence of IPV

in this study sample, it is likely that the interview guide in this study was insufficient to elicit this link between IPV and covert contraceptive use among study respondents. Findings from this study suggest that further research is needed in India on prevalence, motivations, and consequences of covert contraceptive use, particularly to shed light on how covert use may be related to other issues in addition to IPV in the Indian context. Moreover, a close understanding of women's motivations and efforts to seek contraception covertly may provide invaluable intervention avenues for program planners to support women in other areas.

One of the most striking findings in this study was that although almost half the women respondents in this study had control over family finances and 84 percent of women reported being engaged in some form of paid work, close to two-thirds of all respondents reported having experienced prior or current episodes of IPV. This study found that almost 65 percent of women respondents had experienced prior or current episodes of IPV, vastly surpassing results from a 2005-06 nationwide survey in India that found that 40 percent of women reported having experienced IPV (International Institute for Population & Sciences (IIPS) and Macro International, 2007). Yet, IPV in this study did not appear to vary across social class, caste, household structure, or type of marriage, consistent with findings from other research in India (Stanley, 2012; Nanda et al., 2014). Women respondents in the present study, however, often cited husbands' alcoholism as related to instances of IPV. Research in India has demonstrated that of the 21 percent of men who consume alcohol nationally, poor and marginalized men comprise a disproportionate segment, and over half of the men who drink in India are categorized as heavy drinkers (Neufeld, Peters, Rani, Bonu, & Brooner, 2005; Ray, 2004; Subramanian, Smith, & Subramanyam, 2006). Additionally, consistent with the present study, recent research in India has demonstrated a

heightened IPV profile among women married to alcoholic men (Mahapatro, Gupta, & Gupta, 2012; Shrivastava & Shrivastava, 2013; B. P. Singh, Singh, & Singh, 2014; Stanley, 2012).

Prior research has established that gender norms conducive to male domination often lead to a higher rate of violence towards women by their male partners (Pulerwitz, Michaelis, Verma, & Weiss, 2010), and violence against women has been shown to have severe consequences for women's physical, sexual, mental, and reproductive health outcomes (Campbell, 2002). In addition to ideologies regarding male domination, research has demonstrated that alcohol abuse, poverty, low social and economic status among women, and relationship conflicts can exacerbate IPV (Jewkes, 2002). In recent years, IPV has been of substantial concern to scholars and policy makers in India, and increasing attention to IPV has emerged in both the social and political arena over the past decade. For example, the Government of India instigated the "Protection of Women from Domestic Violence Act" in 2004, and the north Indian state of Jammu and Kashmir enacted its own legislation titled "Jammu and Kashmir Protection of Women from Domestic Violence Act, 2010" (Government of Jammu and Kashmir Civil Secretariat - Law Department, 2010; Nanda et al., 2014). Additionally, several campaigns have attempted to bring attention IPV and violence against women in general (Nanda et al., 2014).

Overall, evidence from India shows that both men and women are socialized to accept men's dominance over women, including when it is expressed as physical and sexual violence towards women by their male partners (George & Jaswal, 1995; Khan, Barge, Sadhwani, & Kale, 2005; Maitra & Schensul, 2004; Nanda et al., 2014; Santhya, Haberland, Ram, Sinha, & Mohanty, 2007). In the present study, it did not appear as though women had alliances within their family or communities that would encourage them to leave their husbands in the long-term due to IPV. In addition, men in this study explained how family members (often other female relatives) convinced

their wives to return to their marital homes after having left due to an episode of IPV. These findings suggest that other women accepted patriarchal norms and thus reinforced the gendered expectations of men's violence towards their wives (and subsequently the local gender regime) in this community.

In the present study, although physical and sexual violence had adverse effects - both physical and emotional as evidenced by the women's interviews - none of the study respondents indicated having sought health care of any kind following an instance of IPV. Moreover, both men's and women's descriptions of IPV indicated a high degree of normalization in this community, with no health or legal recourse. Interview data from this study did not elicit the extent or severity of physical violence women experienced. It is possible that women did not feel that the severity of the physical violence warranted seeking health care. However, women did describe the severity of sexual violence, yet respondents did not indicate seeking health care after episodes of sexual violence - further supporting the notion of normalized IPV in this community. Ironically, although findings in this study strongly suggested that public spaces such as the main street were thought to be risky for women, the prevalence of IPV in this community indicates that it was, in fact, the private household spaces where women experienced most bodily danger.

An interesting body of research in India focusing on the impact of women's social and economic empowerment on experiences of IPV presents mixed findings. Some studies have found that women with higher levels of education and socioeconomic status experienced fewer instances of IPV, and women residing in urban areas were less prone to experiencing IPV as compared to their rural counterparts (Hollander, 2006; Nanda et al., 2014). In contrast, a study by Weitzman (2014) using data from the National Family Health Survey 2005-06 concluded that women with relatively higher education, employment, or earnings status experienced more frequent and severe

IPV as compared to women with lower status, thereby suggesting that women's higher status threatened patriarchal norms and was countered with violence. There exists a sizable body of research in the US about men being unable to attain or sustain ideals of hegemonic masculinity - such as being the primary bread winner and having economic and interpersonal power within the marriage and family - and seeking alternate forms of masculinity (Connell & Messerschmidt, 2005; Liebow, 1967; Wilson, 2011, 2012). Connell's more recent work on non-hegemonic masculinity has emphasized the dynamic nature of gender regimes, particularly in the global South where gender relation configurations are informed by rapid shifts in local political economies (Connell, 2012). Within a theoretical framework that explores hegemonic and alternate masculinities, heightened IPV towards women may reflect men's limited or decreased abilities to enact idealized forms of masculinity. As research in India thus far suggests, the links between women's social and economic empowerment and IPV are complex, therefore highlighting the need for further study to clarify the nuances of this relationship and better inform program planners and policymakers.

Interview data from male respondents in this study indicated that they did not feel they had to resolve fights with their wives, or convince their wives to come back to their homes if women had left in the aftermath of a violent fight. Male respondents often claimed that other family members, usually women, would eventually succeed in convincing the women to return to their husbands and homes. It is possible that these responses from men in the study reflect a social conditioning or social desirability bias, where men may have been enacting hegemonic masculine norms and ideals in the presence of the male translator. Furthermore, although many women reported experiences of IPV, none of the women respondents in this study indicated that they had left their homes after a violent fight (although some of the male respondents did indicate that their

wives temporarily left after a violent episode). This lack of reporting from women may have been due to the interview approach to issues related to IPV that did not pursue this line of questions. Women might have also refrained from reporting having left their husbands after a violent fight due to prevailing gender norms in the community that discourage such behaviors.

The characterization of a good wife's roles and duties as more domestic and family-centric compared to men's in this study aligns with studies of gendered socialization and expectations of roles within Indian families and households (Gore, 1977; Gupta, 1995; Ram, Strohschein, & Gaur, 2014; Verma & Lhungdim, 2004). Interestingly, neither men nor women in this study cited non-violence as an important trait in a good spouse, despite the high presence of IPV in this sample. It is possible that study respondents considered non-violence to fall within the larger traits of taking care of the family and being affectionate. Interestingly, although 84 percent of women in the present study indicated that they were engaged in paid work, neither men nor women cited income-earning capabilities as a characteristic of a good wife. These findings may reflect prevailing gender norms in this community that expect men to be primary breadwinners, while relegating women's work outside of the home as secondary. Additionally, whereas numerous men specified a good wife as one who would take good care of the husband and children, women generally described a good husband as one who would take care of the overall family rather than the wife specifically. Neither men nor women acknowledged women taking care of themselves and their wellbeing as a desirable trait in a good wife. These findings highlight Nussbaum's (1999) notion that at the core of women's empowerment and wellbeing is the recognition that each woman must be considered an end in and of herself rather than a means to another person's ends.

There exists a small, but valuable, body of research that has explored the sexual behaviors and experiences of urban low-income and/or rural men and women in India. These studies have



documented patterns of pre-marital and extramarital relations, the impact of pornography and substance abuse, behaviors of men who have sex with men, communication within marital relationships, existing sexual experiences, and contraception and fertility desires (for example, Maitra & Schensul, 2004; Verma & Lhungdim, 2004). One ethnographic study conducted among low-income women in Mumbai investigated women's understandings of sexuality and the impact of socioeconomic conditions on women's sexual behaviors. Women explained that sexual pleasure was a notion that they had only understood over time because they had grown up believing that sex was "sinful" and "dirty", therefore decoupling sex from pleasure. Moreover, women stated that they had been taught that their roles as wives was to fulfill their husbands' desires – a notion that was then reinforced in marital relations, sometimes via sexual violence (George & Jaswal, 1995). In a study by Khan et al. (2005) exploring the experience of sexuality among newly married women in Gujarat and Bojko et al. (2010) examining marital sex in the urban slums of Mumbai, the researchers found salient themes that were consistent with the present study as well as other research in India: strong beliefs about the importance of fulfilling husbands' sexual desires, experiences of non-consensual sex, and concerns about husbands' accusations of infidelity if wives refused sex. This research in addition to Lamb's (2000) ethnographic research in rural Bengal, India on aging and gender highlights the notion that women's sexuality, in contrast to men's, is often understood and experienced within the context of reproduction rather than sexual pleasure in and of itself. Although limited, existing work on sexuality and sexual behaviors related to women in India suggests that there is a need for research and intervention work that focuses on facilitating safe, consensual, and pleasurable sexual experiences for women's overall health, safety, and wellbeing.

## LIMITATIONS

A major design limitation of this study was that men and women were not interviewed concurrently. Women were treated as index respondents and asked if they would be willing to provide their husbands' name and contact information for study recruitment at a later time. Therefore, data in this study may be contaminated due to conversations between women and their husbands about the interview process and content prior to men's interviews. Furthermore, the majority of respondents in this study (71 percent of women and 61 percent of men) identified as being from the Backward rather than Scheduled caste. Therefore, it is possible that study findings are skewed towards the experiences of BC participants. Finally, because it was relatively challenging to recruit and schedule interviews with male respondents, sensitive questions and probes regarding physical and sexual violence were not pursued extensively in order to mitigate obstacles to future recruitment of men in the community. This has likely led to gaps in study findings regarding IPV in this study.

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## **Institutional Power and Women's Health: Using Foucault's bio-power to evaluate cervical cancer screening in rural Tamil Nadu, India**

### **INTRODUCTION**

Cervical cancer has been reported to be the third most prevalent cancer among women globally, with the developing world carrying a disproportionately large burden of disease. According to reports by GLOBOCAN, there were approximately 529,000 cases of cervical cancer worldwide in 2008, and of these, an estimated 275,000 resulted in deaths. Over 85 percent of these cases are reported to have occurred in low and middle-income countries, and 88 percent of deaths worldwide from cervical cancer also occurred in developing countries. India accounts for about a quarter of the world's burden of cervical cancer cases at 25.4 percent and 26.5 percent of worldwide cervical cancer-related morbidity and mortality. Moreover, the age-adjusted incidence rate of cervical cancer in India is 27.0 and the mortality rate is 15.2 per 100,000 - higher than average rates of incidence and mortality across the South Central Asia region (de Sanjosé et al., 2012; Ferlay et al., 2010; WHO/ICO, 2010). de Sanjosé et al. (2012) report that there are approximately 134,420 new cases of cervical cancer every year in India.

There exists a large body of research demonstrating the importance of early detection and screening to reduce cervical cancer morbidity and mortality (Christe, Mohanambal, Ramamurthy, & Snehaa, 2008; Cuzick et al., 2008). Although Pap smears are the most common screening method for cervical abnormalities in Western countries, the more low-cost method of visual inspection of the cervix using acetic acid (VIA), Lugol's iodine (VILI), or a combination of both, is used in resource-poor settings such as rural India (Sankaranarayanan, Gaffikin, Jacob, Sellors, & Robles, 2005; Sherris et al., 2009). Research has shown that once-in-a-lifetime VIA screening for women in their thirties in India can reduce lifetime risk for cervical cancer by 38 percent, and

death from cervical cancer by 66 percent (Sankaranarayanan et al., 2007). In addition, women with pre-invasive cervical lesions demonstrate a 5-year survival rate of almost 100 percent, highlighting the treatment-effectiveness for and curability of early stage disease.

Tamil Nadu has been widely cited as having a strong and progressive public health platform as compared to other states in India (Gupta et al., 2010; Satia, Misra, Arora, & Neogi, 2014). Therefore, it is not surprising that Tamil Nadu has been a primary site for initial and ongoing research on cervical cancer in India (Gajalakshmi, Krishnamurthi, Ananth, & Shanta, 1996; Gajalakshmi, Rajaraman, & Shanta, 2000; Rengaswamy Sankaranarayanan, Budukh, & Rajkumar, 2001; Sureshkumar, Shanmughapriya, Das, & Natarajaseenivasan, 2015; Thulaseedharan et al., 2015). One study that conducted state-level analysis in India indicated that Tamil Nadu had a high cervical cancer mortality rate of 35.7 (per 100,000) - over twice the national average (16.0 per 100,000) and the average in rural India (16.6 per 100,000)<sup>3</sup> (Dikshit et al., 2012). In 2005, the Government of Tamil Nadu, in partnership with the World Bank, established the Tamil Nadu Health Systems Project (TNHSP) - an extensive initiative to develop a health system that is accessible, equitable, and effective. Included in the project's vast health care agenda was a free VIA/VILI screening program for cervical cancer at primary public clinics. The cervical cancer control program has been piloted in two districts in Tamil Nadu - Theni and Thanjavur – and screening has been conducted in 58 public primary health clinics in Tamil Nadu as part of the pilot program. Approximately 2.8 million women have reportedly been screened with an estimated 121,000 positive cases identified (TNHSP, n.d.). Although the TNHSP is a public government-

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<sup>3</sup> Although rates of cervical cancer in Tamil Nadu are high compared to global rates, it is possible that Dikshit et al.'s (2012) findings suggesting that Tamil Nadu has exceptionally high rates as compared to the rest of India is an artifact of over-representation of data from Tamil Nadu. Because Tamil Nadu has historically had one of the strongest public health systems - including surveillance - in India (see Appendix A for more context on this), it is possible that more cases are identified as compared to other states in India. Moreover, much of the cervical cancer screening research in India has been conducted in Tamil Nadu, which may also contribute to the higher identification of cases as compared to other states.

supported initiative, some private primary health initiatives (such as one that has been included in the present study) have also adopted and implemented the TNHSP's cervical cancer control program protocol.

The objective of the initial project from which this analysis derives was to understand the barriers to and facilitators for cervical cancer screening among women in one rural community in Tamil Nadu. This study was conducted in a rural community in Tamil Nadu where most medical care was offered by two major primary health clinics - one public and one private - both of which followed the TNHSP's protocol for cervical cancer prevention and offered screening free of cost to women. In the course of conducting this research, I was struck by what appeared to be important discrepancies between TNHSP's cervical cancer screening program goals and on-the-ground implementation of the program, leading me to explore structural and institutional influences that might account for these discrepancies. Therefore, this descriptive paper investigates structural dimensions of cervical cancer screening among women such as spatial organization and medical power at clinic sites, communication about the disease between health workers and patients, categorization of risk, and involuntary screening. I will identify and interpret these observations using a theoretical lens of institutional power at the clinic level as well as at the broader institutional level of state health care agencies. These observations and interpretations are particularly salient as the State Government of Tamil Nadu has expressed its intentions to demonstrate the effectiveness of the TNHSP screening program and subsequently scale-up the program to all 32 districts in Tamil Nadu (Shanmugam, 2015; TNHSP, n.d.), serving over 14 million women aged 30 years and above in the state (Shanmugam, 2015).

## **METHODS**

### **Study Site**

This study was conducted in a mid-sized village in the Thanjavur district of Tamil Nadu, India with a total population of approximately 4000 in 2011 (Directorate of Census Operations, 2011). Although caste-based hierarchy is not supported by the Indian constitution, caste continues to be a defining social structure in India, both politically and socially. The majority of individuals in this village identified as being from either the Scheduled caste (SC) or Backward caste (BC). According to data from the Census of India in 2011, over 31 percent of the study site village comprises SC members, with the majority of the remaining population identifying as BC (Directorate of Census Operations, 2011). The categorical definitions of Backward and Scheduled castes by the Indian government – and the ways in which these definitions inform social relations in India - have experienced significant alterations from pre and post-Indian Independence eras, with delineations of caste boundaries being an ongoing political and social discussion even today. In post-Independence modern day India, Backward caste is broadly identified as: 1. The inclusive group of all those who need special treatment from the Government, and 2. A level higher than scheduled castes and tribes but nonetheless socially and educationally backward (Galanter, 1978; Ramaiah, 1992). SC families typically comprise the lowest ranked social group in the caste hierarchy, and are often socially marginalized and economically poor. SC family homes are typically spatially segregated from those of higher castes, further creating social exclusion and making access to services challenging (Kumar & Gupta, 2015; Mohindra, Haddad, & Narayana, 2006). These general social and structural characteristics of SC populations were reflected at the study site as evidenced by caste-based government subsidies and provisions (such as cement housing and gas provisions for cooking stoves for SC households), anecdotes of current and past



caste relations and tensions by community members (for example, caste-based riots that had occurred in the past and even during my time in the field), and the spatial organization and boundaries by caste in the village. Moreover, many of the SC members in this village, both men and women, were employed for manual labor in agricultural land owned by BC community members - however, there was no evidence of BC members being employees of SC members in this community.

The closest town to the village was Thanjavur, approximately 35 kilometers from the village. The largest and main street runs through the middle of the village, dividing the village into two distinct neighborhoods – the SC and BC sides of the village. The village’s main centers of business such as banks, small grocery stalls and convenience stores, tea and snack stalls, places of religious worship, and ceremonial event halls, were all located on the main street. There were two main primary health care facilities in the village – one private and one public clinic - where all health services were offered free of charge. The private clinic was run by a not-for-profit health organization and the public clinic was a government-run primary health facility. The private clinic was located at the very center of the village on the main road, and was adjacent to a financial services provider on one side and a tea stall on the other. The public clinic was also located centrally in the village, but slightly towards the interior of the BC neighborhood from the main street. The private clinic was typically staffed with one BC community health worker and one doctor. Although the private clinic was staffed primarily with one particular female doctor, on occasion other female doctors from the organizational network would act as substitutes at the clinic. During the study period, a male doctor acted as a substitute at the private clinic on only one day. The public clinic was staffed by formally trained nurses and doctors, and only one particular nurse and one particular doctor in the clinic (both women) focused on women’s reproductive and

sexual health issues. Although health workers generally did not report their own caste affiliations, based on my observations - specifically how health workers referred to SC community members during conversations- it appeared as though none were from the SC community. Only one private clinic health worker explicitly self-identified as being a member of the BC community.

### **Sampling and Data Collection**

The study sample for this analysis consisted of 45 community women and 14 health workers. The health workers in this sample included the following: 1. Five private clinic doctors (four women, one man), 2. One public clinic doctor (a woman), 3. Seven public clinic community health workers (all women), and 4. One public clinic nurse (a woman). The eligibility criteria for community women were: over the age of 26 years<sup>4</sup>, currently married, a local resident of the village, and no history of a hysterectomy. Initial recruitment of community women occurred within the private clinic. Recruitment was initiated by a female translator who would discreetly approach potential participants in the waiting room and inquire about their interest to participate in the study. If affirmative, the translator and I would follow-up with a study screener to assess eligibility (which took about three minutes). If eligible, women were informed immediately and given a copy of the informed consent form to review (or be assisted in reviewing the form by the translator if the participant required help). Following this, the translator scheduled a convenient time to conduct the interview with the participant.

Chain-referral sampling was used concurrently with clinic recruitment later in the study period to increase SC participant recruitment since in-clinic recruitment on its own yielded primarily BC participants in the study. Most community women participants reported using both

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<sup>4</sup> During preliminary research, a health worker from the private clinic site informed me that screening was typically offered to married women over the age of 26 years. As a result, the eligibility criterion for women in the study was limited to women over the age of 26 who had been offered screening services.

the public and private health facilities, and many had received cervical cancer screening at one or the other of these facilities. All health workers who were interviewed were associated with the private clinic network, with the exception of the women's health doctor and nurse at the public clinic. All interviews with health workers were formal interviews, with the exception of an informal interview with the public clinic nurse who conducted and maintained records for all cervical cancer screening activities at the public facility.

Data collection for this study included a combination of descriptive surveys (for community women), in-depth semi-structured interviews (for community women and health workers), and over 240 hours of participant observation (primarily at the private clinic). Descriptive surveys gathered demographic information about the sample, and the interview guides explored topics such as knowledge and experiences with seeking health care (and in particular cervical cancer screening), facilitators and barriers to seeking care, and aspects of interpersonal and structural power relations. Descriptive surveys and interviews were conducted in the local Tamil dialect with the assistance of four translators (three women and one man) who were familiar with the region and the dialect. All interviews with community women participants were conducted by women translators, whereas most interviews with health workers were conducted with the assistance of the male translator. Moreover, all interviews were conducted in a private space and confidentiality was ensured at all times. The duration for interviews was between 60 to 75 minutes.

All translators were trained for four weeks prior to the commencement of data collection to enable familiarity with the theoretical framework, structure, and purpose of the interview guide. I also conducted training for translators specifically for qualitative interviewing techniques, including how to use neutral probing, how to follow-up on responses, how to handle unanticipated

responses, and issues related to privacy and confidentiality. Furthermore, data quality checks were conducted via weekly meetings with all translators and myself to discuss study progress, issues with conducting interviews, and best practice strategies.

Participants in the study were compensated for their time with Rs. 100 (US\$1.59). All sections of the informed consent form were discussed in detail with participants and their signatures were acquired prior to all data collection. Interviews were audio-recorded and de-identified before simultaneous translation and transcription into English by an external transcription service. Institutional Review Board approval for this study was obtained from both the Columbia University Medical Center and the Apollo Hospitals Educational & Research Foundation in India. Furthermore, authorization for access to public clinic staff was obtained from the State Department of Health Services branch in Thanjavur, Tamil Nadu.

### **Data Analyses**

Descriptive data analyses were conducted using Stata Data Analysis and Statistical Software (Version 9) and qualitative data management and analysis was conducted using NVivo 10 software. Interview transcripts and field notes from participant observation were reviewed numerous times to enable familiarity with data. Where appropriate, thematic analysis was used to develop a coding framework and identify major themes from the data (Boyatzis, 1998; Braun & Clarke, 2006). Braun & Clarke (2006) define thematic analysis as “a method for identifying, analyzing and reporting patterns (themes) within data” (p. 79). This method of analysis is grounded in a careful review of the transcripts and field notes to develop an initial set of themes that closely aligned with the original domains of the interview guide. Interview data and field notes were coded broadly based on a subsequent close reading of the data, and initial codes were identified based on repeated patterns or meanings in the data that elicited insight into the overall research inquiry

(Braun & Clarke, 2006). These codes were further examined for intersections and relationships. Following this, a list of candidate themes was developed and interview data and field notes were re-coded for all relevant text. Broad coding for relevant text enabled the preservation of context in the interview data and field notes. A structured coding framework was created where individual codes were clearly defined and elucidated with relevant sections of data from interview transcripts and field notes. The coding framework was shared and analyzed with all four translators for consensus, and disagreements were carefully considered and resolved with further discussion.

## **RESULTS**

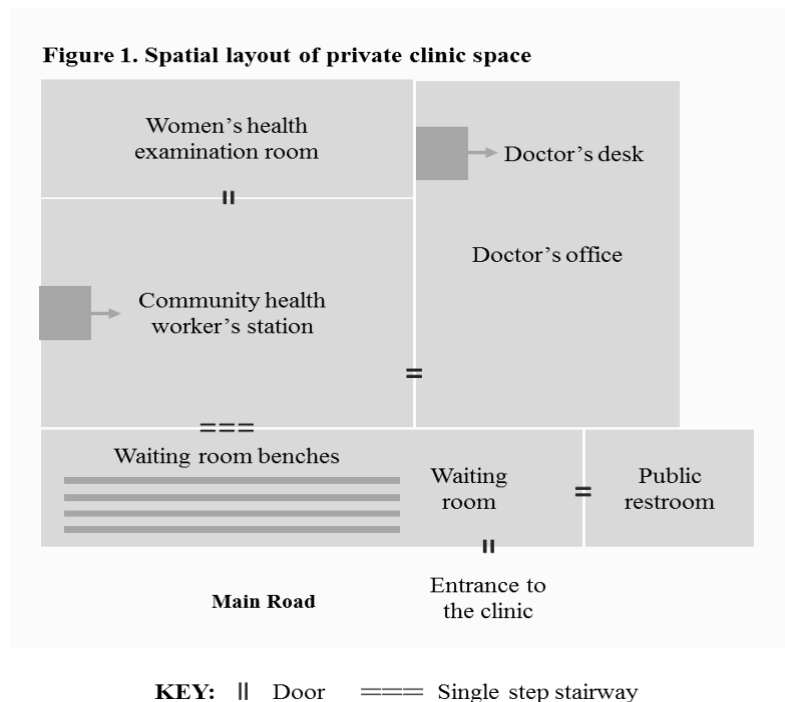
Findings from this study focus primarily on structural dimensions of cervical cancer screening such as spatial organization and medical power at clinic sites, communication about the disease between health workers and patients, categorization of risk, and involuntary screening. All study participants reported that they had been offered free cervical cancer screening at one of the two health facilities. Approximately 64 percent (n=29) of community women participants had been screened for cervical cancer at either the public or the private health clinic. However, only 46 percent of the SC participants (n=6) had been screened for cervical cancer as compared to 72 percent of the BC participants (n=23).

### **Themes**

Four major themes emerged from the data analysis with regard to on-the-ground implementation of the cervical cancer screening program for women at both the public and private health facilities: medical power and space, poor communication between health workers and patients about the disease, differential categorization of risk, and involuntary screening.

### *Medical power and space*

The social hierarchy of medical care in India (and elsewhere) was reflected in the organization of clinic space. The clinic consisted of four main rooms (see Figure 1): 1. The waiting room, 2. The doctor's office (partitioned off with a full wall and door), 3. The space with the community health worker's station, and 4. The women's health examination room (furnished with an examination table with stirrups for patients and partitioned off by a partial wall leaving a 1.5 foot gap between the wall and the ceiling). Upon entry into the clinic, the first space of access was the waiting room. The community health worker's station was located on a raised platform past the waiting area. This station included an office chair and a marble desk-counter, partitioning the community health worker from the rest of the space. At the far end of the space, past the community health worker station was the women's health examination room (the entrance to which directly faced the waiting room). The entrance to the doctor's office was located across from the community health worker's station.



All services at the clinic, unless in the case of an emergency, were conducted on a first-come-first-served basis. Clinic visitors typically walked into the clinic and seated themselves on the benches in the waiting room. The community health worker would then walk over to the visitor and ask for the purpose of the visit. The visitor would be asked to climb the single-stair stairway to the portion of the room where the community health worker's station was located. The visitor would be asked to sit on a chair or stool while the community health worker asked more detailed questions about the purpose of the visit and collected biometric information (such as weight, height, temperature, blood pressure etc.) as needed. Following this, the patient would be asked to return to the waiting room benches until the doctor became available for patient consultation. Upon the doctor's availability, the community health worker would call for the visitor and escort him or her into the doctor's office. The community health worker would remain in the doctor's office for part of or the entire duration of the consultation, as per the doctor's request.

The women's health examination room, unlike the doctor's office, did not provide complete privacy for patients due to the partial wall mentioned previously. Although activities within the room could not be seen, entry and exit of patients into the room could be noted by any observer in the waiting room, or even the main road beyond the waiting room since the clinic windows were made of metal grills. Moreover, although conversations could not be clearly overheard (especially if a cooling fan was turned on in the waiting room or by the community health worker's station), the examination room was far from sound proof for observers in the waiting room. Finally, given the compact nature of the overall space and the lack of discretion when entering the women's health examination room, participant observation led me to believe that the space was not (from my own perspective) conducive to either privacy or comfort, given the type of examinations being conducted. However, it is pertinent to note that I was unable to ask

women or health workers about their own perceptions of privacy or the impact of the lack of privacy as related to willingness to undergo screening in this setting.

Although this study did not include extensive participant observation in the public clinic, basic observation indicated the clinic's general spatial organization was similar to that of the private clinic. Visitors would enter the clinic into a main waiting area and report to the patient counter at the front of the clinic to indicate the purpose of the visit. Following this, visitors would be asked to wait in the waiting room until a nurse could escort them to the "screening counter". The screening counter was an area off to the side of the waiting area where relevant biometric measurements were taken for patients. It is important to note that nurses would enquire about past cervical cancer screening activity at the screening counter. If a patient had not been screened for cervical cancer in prior visits, nurses would ask that they be screened at this time. Women's health examination rooms were located at a further interior location in the clinic, and not visible from the waiting room. Upon completion of appropriate screening and biometric measurements, visitors would be asked to wait in the waiting room until the doctor was available to see them. The nurse would escort the patient into the doctor's office once the doctor became available for a patient consultation. The women's health doctor's office was located at the far back end of the public clinic's space, and was adjacent to a space (partitioned by a movable rack of curtains) used for labor and delivery services.

Spatial boundaries and power differentials within the private clinic were practiced in two major dimensions: 1. Between clinic staff and visitors (with increased power differentials between visitor-doctor as compared to visitor-community health worker), and 2. Among clinic staff (with the doctor being in a higher position of power). Field notes and analytical memo excerpts from



participant observation in the private clinic provide some insight into how physical space, boundaries, and relationships of power materialized in the clinic space:

[Community health worker] is sitting by her station with a laptop but has her back partially turned away from the waiting room while she untangles the wiring for the fan. A woman (maybe 25 years old?) enters the clinic with 2 children – a toddler girl and a baby boy. The clinic is empty at this time of the afternoon (around 2pm) and it is a very hot day outside. After about a minute of standing by the steps, the visitor realizes that [community health worker] won't turn around to see her until she is satisfied with the situation with the wiring. She stands by the steps trying to catch [community health worker's] attention, but is unable to be heard over the sound of the fan (another minute). The visitor looks at me as though to see if I would walk up the stair to the mid-section of the clinic to let [community health worker] know of the visitor's presence. I smile at her but I continue taking notes. The toddler gets restless and starts to become fussy and the visitor seats herself on the benches, awaiting [community health worker's] attention. Duration of entry into clinic to this point is about 4 minutes. (*Field notes*)...The stairs (although a single step really) appear to represent and provide meaning to an understated yet unquestionable boundary between visitors and clinical staff, whose authority over the space is apparent. [Community health worker's] role as a gatekeeper to the doctor and to the clinic's services in general is highlighted repeatedly in her interactions with the visitors (enquiring about the purpose of their visit, assessing their needs, escorting them to the appropriate areas at the appropriate times, leading them into doctor's office for consultation and providing them with medicines or medical advice as per the doctor's orders) and with the doctor (leading visitors into the doctor's office upon doctor's request, inquiring if the doctor needs any further information or materials, responding to the doctor's inquiries, leading visitors out of the doctor's office, asking the doctor when to send in the next visitor). Spatial boundaries were tacitly understood by all visitors – neither the spatial boundaries nor the authority of the clinic staff in the space were ever explained or overtly stated or challenged. (*Analytical memo*)

As Figure 1. and the field note entry indicate, spatial boundaries in the clinic were explicit, delineated architecturally in the form of stairs and doors. However, spatial boundaries in the clinic also represented implicit manifestations of power dynamics - between patients and clinic staff as well as between the doctor and the community health worker – that were well understood and carefully maintained by clinic staff and patients. Furthermore, during participant observation, I did not observe patients disagree, question, or argue with the health workers at any time. In fact,

patients appeared to strictly adhere to the norms of status hierarchies and carefully follow all instructions related to conduct from health workers in the clinic.

### ***Poor communication between health workers and patients***

In-depth interviews with community women and health workers revealed that cervical cancer was often confused with uterine cancer. This appeared to be a linguistic challenge among respondents and health workers, as there is no direct word for the cervix in Tamil - rather the cervix was descriptively referred to as the ‘mouth of the uterus’ and cervical cancer as “uterine mouth cancer”. However, in conversations between health workers and patients, and during interviews, cervical cancer was often referred to as uterine cancer by both health workers as well as patients. It appeared as though health workers, although aware of the distinction between cervical and uterine cancers, used the colloquial term for cervical cancer (which dropped the “mouth” part of the terminology in Tamil) when communicating with community women.

In addition, although almost 58 percent (n=26) of the community women in my sample had undergone screening themselves, respondents indicated mixed levels of biomedical knowledge about the disease, risk factors, prevention, and treatment. Many community women reported having heard of cervical (or “uterine”) cancer but expressed limited knowledge beyond the fact that it was a cancer of the reproductive organs in women and could be easily treated with early diagnosis. In fact, some respondents mistook ultrasounds they had received during pregnancy as cervical cancer screening. When asked what caused cervical cancer, many respondents cited eating habits or poor nutrition. One 35 year old BC respondent who had been screened was aware that cervical cancer was easily treatable if caught early, but expressed confusion about how it was caused. She stated, “If it is diagnosed in the starting stage it will be cured easily and it always appear in the infected body...I don’t know the reason; will it come because of the calcium

deficiency?” Another 29 year old BC respondent who had been offered screening but had declined relayed, “[Someone] told about it. But don’t know whether when we eat something it will spread.” One respondent explained that bad water quality caused cervical cancer. This 51 year old BC woman who had been screened stated that cervical cancer was on the rise because “Water is not good here. Water here is salty... So, it is coming only because of the water. All diseases like AIDS, cancer, fever, and stomach aches all are because of the bad water.” Therefore, although most community women had heard of cervical cancer and understood that screening was available, biomedical knowledge about risk factors was notably low.

It is important to note that only nine percent of community women in this study sample identified sexual activity as a risk factor for cervical cancer. In cases where women had knowledge of multiple sexual partners as a risk factor, they spoke of “bad behaviors” or “wrong relationships” and the importance of engaging in sexual relations with marital partners only. One 42 year old BC woman stated, “I heard that if you behave wrongly, you will get that disease.” Another 40 year old BC woman who could not identify where in the body cervical cancer occurred reported,

They say it is a sexually transmitted disease, it is mainly caused because of the wrong relationships, it is caused because of the sexual contact outside the marriage life, so they say that if we have those kind of relationship then this disease is easily transmitted from others. (40 year old, BC respondent)

The vast majority of study participants did not identify engagement in sexual activity or multiple sexual partnerships as a risk factors for cervical cancer. In the cases where women did identify that sexual activity and multiple sexual partnerships were risk factors, they generally attributed the fault to women rather than their marital partners, whose sexual behaviors could also present disease risk for women.

Additionally, only 11 percent of study participants provided a detailed account of symptoms and disease progression of cervical cancer. One 37 year old BC respondent described,

It comes in uterus in the form of cyst. If over bleeding they have asked to see the doctor. It could be cured, if shown to the doctors and treated at the beginning, before it spreads. If ignored and cyst become larger, then it could result in cancer. Because of over bleeding. It comes for people with over bleeding or for people having heavy white discharge. (37 year old, BC respondent)

This respondent was particularly well informed and was able to broadly explain symptoms, manifestation, diagnosis, and treatment. Another 45 year old SC respondent clarified, “if an infection is there in the uterus, they say that there are chances of it becoming a cancer...if it is a cancer, we can remove uterus or outside the uterus the cancer comes.” Although a few community women in the study had a reasonable overall understanding of cervical cancer, screening, and treatment as described in the TNHSP program description, many participants in this study expressed confusion about the disease.

The TNHSP identifies several key messages in the primary intervention of disease awareness in the community: information about the burden of cervical cancer, risk factors, early detection and screening, information on the difference between pre-malignant and malignant cases, easy treatment with early detection, and the availability of free screening services by women-only staff. The private clinic network had made some efforts towards community mobilization via presentations and workshops with community women, but biomedical knowledge among study participants was still limited. Based on informal conversations with health workers and participant observation, it was evident that health workers provided some information and counseling to community women, or sometimes even couples, on a case-by-case basis when trying to convince

women to get screened during clinic visits. This counseling usually entailed informing women that cervical cancer exists, that it was easily curable if identified early, that they should get screened if they are married or over the age of 30, and that screening is free of cost. However, it appeared as though formal health education about cervical cancer was largely lacking or incomplete in screening programs although the primary intervention in the TNHSP cervical cancer screening policy was to raise awareness in the community.

Additionally, although uptake of screening among women in the SC community was considerably lower than in the BC community - 46 percent versus 72 percent - there were no apparent differences in levels of knowledge or reasons for lack of screening between SC and BC community women. Most participants who had not been screened cited the following reasons: lack of knowledge about screening, shyness, fear, lack of time due to other competing priorities, or feeling it was unnecessary as there were no symptoms. One 51 year old unscreened BC participant explained, "Because, I do not have such complaints. If any complaints I can go for test. But I do not have that problem. So then why should I go for it?" Another 27 year old SC respondent expressed being unable to complete the procedure due to fear even after agreeing to screening. She stated, "I was scared and came out running...When they put the gloves, I ran with fear and came out." Not having time due to competing priorities was also a recurring reason among some participants. One unscreened 30 year old SC participant relayed,

Because I'm going for work I don't get time also how to go and do all the tests , a bit scared and shyness everything is there because of that I haven't done till now, so it is delayed...I am scared of the procedures and how will it be done like that. (30 year old, SC respondent)

Some participants also mentioned that they had not undergone screening because their husbands had expressed fear about the process. For example, one 30 year old unscreened BC respondent stated,

He is really scared. But give me some time. Will definitely convince him and come on some Tuesday...I have to tell that I am really scared since all are telling that this disease spreads everywhere and we should also check this. (30 year old, BC respondent)

Some respondents also expressed that they would agree to screening if it was offered to them again, therefore highlighting that logistics and convenience might be strong barriers to screening for some community women.

### ***Differential categorization of risk***

Participant observation and interview data indicated that although the TNHSP screening protocol proposes to screen all women between the ages of 30 and 60 years regardless of symptoms, marital status was often prioritized over age-related eligibility criterion in clinical practice. Additionally, cervical cancer screening was generally spoken about as a once-in-a-lifetime practice by health workers and community women, with the exception of cases with abnormal VIA/VILI results.

The TNHSP screening policy does not specify marital status as an eligibility criterion for cervical cancer screening – in fact, the policy makes no mention of marital status. However, participant observation and interview data suggested that screening practices in clinics (especially the private clinic) prioritized marital status over age-related criterion. Over 15 percent of community women in the study sample reported to have been screened for cervical cancer while under the age of 30 years. Moreover, during conversations about cervical cancer screening in the community, health workers often emphasized that screening was important for married women in

the community, their implicit assumption being that these women were most at risk for the disease due to sexual activity with their husbands. In addition, during my interview with the women's health physician at the public clinic, I was informed that for those community women who receive positive VIA/VILI results, screening may be repeated after one or two years - but screening was seldom repeated for negative cases that were asymptomatic. Moreover, health practitioners did not discuss the possibility or need for multiple screenings over time with women unless prior results had been reported to be abnormal or positive.

These observations suggest that there are discrepancies in the categorization of high risk individuals for cervical cancer between the policy as it has been drafted and clinical practice as it occurs - i.e., although the TNHSP policy identifies women 30 to 60 years of age as a high risk category, health practitioners on the ground conducted preventative screening as though women who were married were the high risk category for cervical cancer. These discrepancies may be problematic as most cases of cervical cancer take time to progress to a stage where abnormal lesions may be identified via screening (Sankaranarayanan et al., 2007). Therefore, screening married women under the age of 30 years for cervical cancer may not capture the disease progression, and once-in-a-lifetime screening with negative results for cervical cancer may falsely suggest that the patient is not at risk for the disease going forward.

### ***Involuntary screening***

Although the TNHSP policy for cervical cancer screening emphasizes voluntary screening, interviews with health workers at both the public and private clinics indicated that involuntary screening was common in these clinics. Involuntary screening took different forms in the public and private clinics: in the public clinic, involuntary screening was primarily conducted at a systemic level (applied to most incoming community women patients eligible for screening),

whereas in the private clinic involuntary screening was conducted in an arbitrary case-by-case basis depending on the reluctance of individual incoming women patients.

During my interview with the women's health physician at the public clinic, I was informed that it was standard practice for nurses to mandate cervical cancer screening as a prerequisite to being able to see the physician during a clinic visit, even for unrelated health conditions. The physician explained that community women over the age of 30 who entered the clinic could not see her unless they had undergone screening previously, or were willing to undergo screening at the time of the visit, with the exception of emergency cases. She elucidated, "...they come here with some other ailments, so what we have done is whenever a patient more than 30 years steps in, she cannot meet me. She has to first meet the [screening] counter." This physician further stated that most women would not opt-in for screening: "none of the women would voluntarily come and tell you this that I would like to get myself screened, it is very rare, and in a month I may get one patient like that." As a result, it appeared as though cervical cancer screening at the public clinic was primarily opportunistic and involuntary in a systemic manner.

In addition, during an informal conversation with a health worker from the private clinic, the health worker reported that because some community women resisted screening even after a number of visits, the health worker would misinform the patient that the condition she was seeking care for at the time may be related to cervical cancer. This was an attempt on the health worker's part to get patient compliance for screening. Although none of the health workers at the public or private clinics directly indicated that there were concrete screening quotas to fulfill, interview data from health workers (particularly those at the public clinic) signaled that high screening rates at both facilities were strongly encouraged and rewarded through continued funding and allocation of staff and equipment resources. In particular, the public clinic's women's health doctor



emphasized having been able to report high screening rates under her purview to the state government as an indication of the clinic's strong performance and good reputation. At the private clinic, health workers often spoke of high screening rates as a demonstration of credibility for further "expansion" of the organization. Health workers at the public and private clinics also emphasized the importance of high screening rates for the overall improvement of women's health in the village. It is important to note that although health workers indicated instances of involuntary screening or medical misinformation, women participants in my sample did not themselves identify screening (or communication with health workers about screening) as involuntary or coercive. Moreover, none of the community women in my sample indicated that the medical information they received from health workers at any time was inaccurate.

## **DISCUSSION**

There are numerous study limitations that must be noted to contextualize my observations. All study observations have been compiled from two research sites, a public and private clinic, but health workers who could shed light specifically on screening-related clinic practices were limited to the 2 or 3 health workers at each site who conducted cervical cancer screening. Moreover, the Department of Health Services in Tamil Nadu provided me with restricted authorization for access to the public clinic - although permission was granted for interviewing the women's health physician and nurse, requests for access to the clinic for long-term participant observation were met with notable reluctance (which I did not counter in order to mitigate issues with the little access I had been provided).

Additionally, the majority of community women in this sample identified as being from the Backward rather than Scheduled caste. Seventy-one percent of women in this sample self-reported being BC and 29 percent identified as being from the SC community, closely reflecting

the overall representation of BC and SC members in the village at 69 and 31 percent respectively (Directorate of Census Operations, 2011). Furthermore, the majority of SC participants in this study were recruited via chain-referral sampling rather than in-clinic recruitment. During the data collection period, the majority of women who visited the private clinic were from the BC community. However, descriptive surveys revealed that the majority of SC participants from the sample, despite having to be recruited via chain-referral sampling, had visited one of the two clinics at least once within the last six months. Scholarly literature indicates that, in general, SC community women have lower access to and familiarity with the health system (Kumar & Gupta, 2015; Mohindra et al., 2006), therefore it is possible that BC women visited health facilities more frequently than SC women in the present study (although this was not assessed as part of the data collection process). Observations from this study indicated that there were no marked differences in study findings between the two groups in this study except in actual screening rates – i.e., only 46 percent of SC respondents had been screened for cervical cancer as compared to 72 percent of BC respondents. All participants had been offered screening, so substantially lower rates of screening among SC women as compared to BC women in this study may reflect aspects of higher discomfort or lower familiarity with the medical system in this setting. It is important to note that limitations in my data hindered a meaningful assessment of comfort levels and familiarity with the medical system among community women by caste. As a result, the observations in this study might have been skewed towards the experiences of BC participants. Nevertheless, although generalizability is not a primary goal for qualitative research, given that there are almost 1900 primary care public clinics in Tamil Nadu as of early 2015 (State Health Society - Tamil Nadu, 2015), and the state government intends to expand the TNHSP cervical cancer screening program

to all 32 districts in Tamil Nadu (TNHSP, n.d.; World Bank, 2014), observations from this study raise salient issues to keep in mind during future program planning and implementation.

This study raises a number of important questions about the TNHSP policy on cervical cancer screening and on-the-ground implementation for health workers and policy makers in this region. Although laudable for being one of the first organized cervical cancer control programs in the country, long-term goals of cervical cancer prevention and control are constrained by spatial organization of the clinic, poor communication between health workers and patients about the disease, differential categorization of risk, and involuntary screening practices that could potentially risk trust in medical practitioners. Program planning and implementation efforts for cervical cancer in rural India, where most women often reside in low-income communities with low health literacy, must carefully consider the significant disparities of power between the medical institution and its patients, and the ways in which these disparities may impact screening implementation and overall women's health outcomes in the long-term.

It is useful to use a Foucauldian lens to examine my observations in the present study. Foucault's extensive repertoire of work emphasizes the complex relationship between power, knowledge, and social institutions such as the hospital or clinic. The Foucauldian notion of bio-power, defined as "numerous and diverse techniques for achieving the subjugations of bodies and the control of populations" (Foucault, 1978, p. 140) is particularly relevant given the context of this study. Foucault's use of the term bio-power includes public health practices and risk regulation where mechanisms of power exist to manage large groups of human bodies - i.e., having the power to control populations. Foucault emphasizes that all individuals are not subjected to power in an egalitarian manner – rather some individuals are controlled more than others depending on social factors such as gender, social class, or race (and caste in the Indian context). Foucault postulates

that bio-power, in the context of public health, is a form of social control that emerges from an institutional incentive, both at the state and the clinic level, to foster specific population outcomes, i.e., the reduction of morbidity and mortality (Foucault, 1978). In the context of public health, these incentives may manifest as state-developed, supported, and/or implemented health interventions for target populations. Observations in this study present four major expressions of bio-power as relevant to cervical cancer screening in this setting in rural Tamil Nadu: spatial organization of the clinic, patterns of communication between clinic staff and community women, the categorization of risk that determines who does and does not get screening, and involuntary screening in both the public and private clinics.

Participant observation data from this study demonstrates how the spatial organization of the private clinic is a key expression of bio-power (or powerlessness). My observations indicate that bio-power can be discerned in the use of space to create boundaries, and the intricate ways in which status hierarchies are represented and reproduced both by clinic staff as well as visitors in the private clinic space. The notion of highly implicit but deeply respected spatial boundaries in research related to gender, sexuality, and health has also been demonstrated in studies conducted in settings such as Mexico and Papua New Guinea (Hirsch et al., 2009). Such studies have explored the tacit but powerful boundaries and demarcations of sexual spaces, where extramarital relations occur in physical spaces distinct from marital relations. Numerous researchers have also investigated the intersection of power and space in the specific context of clinical spaces and activities. Brandt & Stone (1999) highlight that spaces designed for health care delivery embed doctrines and rhetoric of professional power, therefore situating them at the intersection of science and culture. Some researchers have also emphasized that health care spaces such as hospitals have historically been organized in a manner that clearly reflects and communicates the social locations

of patients, doctors, and other health care staff (Galison, 1999). For example, Gillespie (2002) uses a family planning clinic in the UK as a case study to demonstrate how structures of architectural space in which family planning services are offered inform unequal power relations and reinforce dominant cultural discourses around family planning. More recently, Sauer (2015) conducted an ethnographic study in a city hospital in Finland where she investigated the ways in which power over a space was enacted in hospital settings, and how power was otherwise constructed, signaled, or symbolized.

The existing body of literature on the intersection of space and power within the medical institution echoes observations from the private clinic in the present study, and what Sauer (2015) describes as “the relative powerlessness of patients actualized in the functional utility, regimentation and discipline” (p. 246) of hospital spaces. Therefore, my observations regarding spatial boundaries and status hierarchies in this study are not particularly unique as compared to most clinical settings in other global locales. However, it appears as though the difference in power between patients and health workers was exceptionally exaggerated, with there being no observable instances of questioning, disagreement, or arguing with the authority of or instructions from health workers in the clinic during over 240 hours of participant observation in this setting. Status hierarchies that are represented and reproduced in the private clinic space may have substantial implications on how women interact with the medical space and staff. For example, women may not feel comfortable about being examined in the women’s health examination room due to the partial wall, and may avoid seeking care rather than express their concerns about the space in instances where the use of the room would be necessary. It is important to note that these inferences about issues with privacy are based on participant observation data. I did not have the opportunity to ask women or health workers about their own perceptions of privacy or the impact

of the lack of privacy on willingness to seek health care. Further research on the impact of spatial and status hierarchies between and within clinic staff and patients in this setting, and rural Tamil Nadu more broadly, is needed to assess how spatial organization and operational protocols of clinics can be enhanced to better serve rural women.

Although over half the community women in this study had received screening at either the public or the private clinic, it is evident from interview data that screening did not always imply high biomedical knowledge about cervical cancer - i.e., risk factors, screening process, interpretations of results, or treatment. These observations about biomedical knowledge appear to be a reflection of poor communication between health workers and patients - perhaps exacerbated by a combination of status hierarchies between health workers and patients, and TNHSP's (and health workers') failure to consider existing non-biomedical models of knowledge about cervical cancer among women. Biomedical information about cervical cancer through the TNHSP program is unlikely to be the only source of information for community women, but rather an addendum to existing local and traditional understandings of the disease. Therefore, the TNHSP's focus on education and awareness about cervical cancer from a biomedical perspective must carefully consider the socio-cultural context of prior understandings about cervical cancer and its causes among community women.

Poor communication between health workers and patients is particularly relevant when linked to observations that indicate manipulation and misinformation of knowledge by health workers in the private clinic - i.e., one could speculate that low levels of biomedical knowledge about the disease among community women further facilitate opportunities for misinformation by health workers as a way to convince women to get cervical cancer screening. Moreover, misinformation is likely to further reproduce or contribute to incomplete or inaccurate knowledge

about cervical cancer among community women. Some community women demonstrated having biomedical knowledge about specific aspects of cervical cancer (such as location in the body, or knowledge about symptoms and tumor growth) but expressed confusion about risk factors or the screening process itself. Studies conducted in the United States on women's knowledge of Pap tests indicate that higher knowledge about the screening process, limitations, and results strongly correlate with a higher likelihood of receiving screening (Dignan et al., 1996) and complying with medically recommended follow-up for abnormal results (Abercrombie, 2001; Yabroff, Kerner, & Mandelblatt, 2000). In one recent study conducted in the state of Kerala, India, findings indicated that knowledge-related variables accounted for half of the self-reported factors that impacted women's ability and desire to undergo cervical cancer screening (Aswathy, Quereshi, Kurian, & Leelamoni, 2012). Observations from the present study suggest that there is a strong need for research on existing understandings of cervical cancer followed by tailored health literacy programs that focus on delivering biomedical information within the context of existing forms of knowledge about the disease. Additionally, program planners must consider that the curriculum of health literacy programs is complicated by the fact that married women's sexuality is presumed to be expressed only with their husbands, effectively making husbands' sexual behaviors a key risk factor to acknowledge.

Women's narratives about causes for cervical cancer that related food and water to bodily disease was particularly interesting in this study. Several studies in India have explored notions of bodily health or contagion as related to food, some particularly in Tamil Nadu (Caplan, 2001; Caplan, 2008; Daniel, 1984; Ferro-Luzzi, 1975; Johnson, White, Boyd, & Cohen, 2011; Lamb, 2000). Caplan (2001) explains that in middle-class Tamil Nadu families residing in Chennai, food is closely associated with ideas of health and wellbeing, bodily substance, and religious notions of

pollution and purity. Furthermore, there exist strong notions of contagion of food that are dependent on factors such as whether the food is cooked or raw, who prepares food for whom (typically related to caste), and the person's bodily state during preparation (for example, having bathed and changed into clean clothing or ensuring that food is not prepared by menstruating women). Ferro-Luzzi's (1975) research has described particular foods women in Tamil Nadu avoided during their life cycles because of the "hotness" or "coldness" of foods (for example, certain dairy products are considered "cold" whereas meat or sweet fruits are considered "hot"), the purity or impurity of food (for example, most products from cows are considered pure whereas all meat is considered to be contaminated by death and therefore impure), or inherent disease or illness-causing properties of certain foods, particularly in babies after the mother's prior consumption (for example, mangoes are thought to cause fits, bottle gourds to cause skin disease, and papaya to cause diarrhea). Although the present study did not explore the specific relationship between food consumption and notions of disease, it appeared that cultural conceptualizations of the food-contagion relationship were present in community women's understandings of cervical cancer.

SC participants in this study reported significantly lower screening uptake as compared to BC participants. However, descriptive survey and interview data did not indicate notable differences in reasons for lack of screening, or access to and familiarity with the health facilities between SC and BC community women. A growing body of research exploring the impact of caste on the uptake of health services and outcomes in India demonstrates significant inequities between lower and higher caste communities (Baraik & Kulkarni, 2006; Baru, Acharya, Shiva Kumar, & Nagaraj, 2010; Borooah, Sabharwal, & Thorat, 2012), particularly in the domain of women's health (Kumar & Gupta, 2015; Mohindra et al., 2006; Sanneving, Trygg, Saxena, Mavalankar, &



Thomsen, 2013). This research has primarily focused on maternal and reproductive health. Women from SC communities have been found to be subject to a multiplicity of burdens such as poverty, social marginalization, and the adverse effects of patriarchy, leading to poorer maternal health outcomes (Kumar & Gupta, 2015; Navaneetham & Dharmalingam, 2002). Evidence of published research that focuses on the impact of caste on women's sexual health outcomes in India, or cervical cancer screening specifically, was not found at this time.

It is possible that this study was unable to elicit nuances underlying differential rates of screening uptake between SC and BC participants due to an insufficient sample size of SC participants. One conceivable reason for the lack of notable difference may be that SC community women frequent the public clinic more often than the private clinic, where study recruitment occurred, but they visit the private clinic as a caregiver for someone else rather than for their own health. As a companion for someone else's care, women participants would not have been subject to involuntary screening practices at the private clinic, and could have avoided screening altogether. However, given the small sample size of 13, it is not reasonable to draw conclusions from the data available in the present study.

Although the TNHSP policy recommends screening for women over the age of 30 years, it appears as though marital status - rather than age - was the criterion that health workers prioritized for cervical cancer screening. In some cases, women who were under the age of 30 years, but married, had received screening from health workers. It is apparent that the medical institution, comprising both the clinics as well as the larger policy-making entities, holds the power to identify and target risk categories. However, it is also apparent that the various entities within the medical institution categorize risk differently, and certain entities such as the clinic have more power to enforce those categories by virtue of being agents of clinical practice. As a result, there

are notable discrepancies in how the TNHSP policy and health workers on the ground identified high risk groups in the community. Moreover, these observations imply that clinical practice in this setting was shaped by prevailing cultural notions that only married women were sexually active and at risk for cervical cancer.

Close attention must be paid to the identification of high-risk categories of patients and optimal age at the time of screening, especially in low resource settings such as India where screening is primarily conducted once-in-a-lifetime. Research using cost-effectiveness modeling in five developing countries predicts that once-in-a-lifetime screening for a 35 year old woman with VIA could reduce lifetime risk for cervical cancer by 25 to 36 percent. Women receiving VIA/VILI screening twice, at ages 35 and 40 years, are predicted to have a 65 percent reduction in lifetime risk for cervical cancer (Goldie et al., 2005). A study conducted in India using a single round of VIA screening followed by immediate cryotherapy treatment found that the greatest public health impact via reduction in cervical cancer incidence and mortality occurred among women aged 30 to 39 years (Sankaranarayanan et al., 2007).

Because screening is only conducted once in a lifetime unless symptomatic in this particular setting, screening women under the age of 30 years may miss capturing high risk cases at the early stages of disease - i.e., women under the age of 30 years may be unlikely to be detected with precancerous lesions even if they remain at risk for cervical cancer in later years. Once-in-a-lifetime screening conducted too early in a women's life cycle raises the possibility that women might not perceive themselves at future risk for cervical cancer once they receive negative results. Therefore, screening too early among women may perpetuate the misconception that they are at no risk for cervical cancer in later years, and women may not take preventative measures until symptomatic. Observations in this study suggest that further research is needed to investigate

whether the eligibility criteria in the policy need to be amended, or whether further training is required for clinical staff so that they better understand the rationales behind the criteria and are compliant with the policy. Women's perceptions of future risk of cancer was not directly explored in the present study. However, given that over 15 percent of the study sample had been screened for cervical cancer prior to age 30 years, additional research is also needed to better understand how women perceive their individual risk for cervical cancer given their screening history.

Observations from this study indicate that involuntary screening occurred in the private and public clinics, both of which offered free medical care. There were two major manifestations and applications of bio-power with regard to involuntary screening in this study setting: 1. Withholding medical care unless patients complied with screening (a direct form of bio-power observed in the public clinic) and 2. Medical misinformation to have patients comply with screening (an indirect form of bio-power observed in the private clinic). Because medical care is offered free of cost at these facilities, these clinics predominantly serve low-income women in the region. As a result, it is low-income women who are primarily subjected to involuntary screening. There appears to be a dearth of research on cervical cancer surveillance of middle- or upper-class Indian women, or more broadly, the general experience of medical autonomy and decision-making among more affluent women in India as compared to low-income women. This is an important area of research that must be further explored in the country. However, one may postulate that middle- or upper-class women in India, who are able to seek care from for-profit medical facilities and pay for medical care, may have more power and control over what their bodies are subjected to within the practice of medicine as compared to low-income women.

Additionally, it is important to highlight the politics of target-based interventions as related to the pressures of funding and performance-related agendas in the larger network of state health

care bureaucracies. Primary care public clinics in Tamil Nadu (and the TNHSP cervical cancer screening program) are under the direct purview of the Health & Welfare Department in the Tamil Nadu State Government (Government of Tamil Nadu, n.d.), and all funding and non-monetary resources for public clinics are allocated by the state government. As a result, public clinics are required to submit data on a variety of clinical activities to the state government, including medical record data on screening activities within the clinics. These factors create institutional pressures on health workers to increase screening rates among their patients and may further foster instances of involuntary screening by health workers. Therefore, it is imperative to invest in proper training and evaluation of screening practices at the clinic level, and instill appropriate measures in screening policies that mitigate instances of involuntary screening due to the pressures of target-based interventions.

Considering the high rates of cervical cancer morbidity in Tamil Nadu, this study's observations raise important questions pertaining to involuntary versus voluntary screening - i.e., what does autonomous choice look like in the face of high morbidity and mortality, and what is the medical institution's role as an institution of power? Although Foucault's conceptualization of bio-power inherently implies that it is a negative force, some recent scholars have interrogated the construct differently and argue that there may be substantial public health advantages to applications of bio-power such as mandatory testing. Work by these scholars suggests that certain forms of bio-power may be beneficial for the control of epidemics and overall population health, or in settings where the screening is for a highly stigmatized health condition (Brady et al., 2009; Johansson, Pedersen, & Andersson, 2011; Markovic, Kesic, Topic, & Matejic, 2005).

Given the invasive nature of VIA/VILI screening, high rates of cervical cancer, low health literacy, and the urgent need to control cervical cancer morbidity and mortality in rural Tamil

Nadu, opt-in voluntary screening (although the gold standard from a Western biomedical ethics perspective) may not prove to be a feasible option for disease control in this population in the immediate future. As an alternative, two approaches to screening with varying degrees of medical paternalism come to mind: mandatory universal screening or opt-out screening. One qualitative study examining barriers to cervical cancer screening in Serbia reported that women were in favor of organized mandatory cervical cancer screening by the Serbian government. Rather than considering mandatory screening a violation of reproductive choice and rights, some women participants in this study expressed that such a policy could rapidly improve women's health outcomes in Serbia. Moreover, participants in this study reported that dominant socio-cultural mores about women's sexuality in combination with the fear of gossip if seen seeking gynecological care were notable barriers for accessing cervical cancer screening. Based on these findings, the researchers concluded that a model for mandatory cervical cancer screening might be most feasible and beneficial in emerging economies where women often face substantial social and economic powerlessness. The researchers also emphasized that mandatory screening may mitigate instances of exposure and gossip in small communities and reduce stigma around gynecological examinations (Markovic et al., 2005). In the present study, the public clinic's screening activities, although cited as voluntary, are in practice an informal implementation of mandatory universal screening at a systemic level. This study did not explore the specific issue of women's attitudes toward mandatory screening policies or their experiences or fear of gossip and stigma. However, future research on organized cervical cancer screening programs in Tamil Nadu, and India broadly, should investigate the advantages and disadvantages of mandatory cervical cancer screening as well as the relationship of mandatory screening to destigmatization in the Indian context. Moreover, future research in this area should pay close attention to potential

structural differences in populations that are highly subjected to mandatory screening and those that are not by virtue of social differences such as class or caste, among others.

Opt-out models have been discussed extensively in the HIV-testing literature and many of the advantages and disadvantages can be extrapolated to models of opt-out screening for cervical cancer. CDC guidelines in 2006 recommended that opt-out testing be used for HIV where screening is part of routine testing unless a patient chooses to opt out of testing (Centers for Disease Control and Prevention, 2006). However, numerous researchers have expressed concerns in the implementation of an opt-out approach. These include issues regarding informed consent violations, ensuring proper understanding among patients that testing may be refused without compromising other medical care, and fostering a health system that respects and supports the principles of informed and autonomous choice (Celada, Merchant, Waxman, & Sherwin, 2011; Johansson et al., 2011; Manson, 2013). Moreover, some critics of opt-out models have argued that an opt-out approach may disproportionately subject socioeconomically disadvantaged populations to testing as compared to the general population, and higher rates of identification of positive cases in these populations may lead to stigma towards these social groups (Celada et al., 2011).

Other scholars have been in support of the state's authority and imperative to take measures to control population health for the greater good of the population. These scholars have argued that the long-term benefit of early detection and treatment for overall wellbeing outweighs potential negative impacts of issues in implementation. Researchers posit that in instances where individuals do not make health-promoting choices, there is a societal responsibility to encourage strategies that are in the best interests for health and wellbeing (Johansson et al., 2011). As in the case of opt-out screening for HIV among pregnant women, advantages for opt-out screening for cervical

cancer include reducing the incidence of preventable disease among vulnerable women, increasing access to testing, increasing the number of women being screened, and the destigmatization and routinizing of screening (U.S. Preventative Services Task Force, 2013).

Further research and planning for cervical cancer screening programs in India must carefully weigh the advantages and disadvantages of mandatory or opt-out screening given the local context. Although these approaches may reduce overall morbidity and stigma related to cervical cancer and screening, screening measures and disease surveillance will likely be applied differentially across social groups. One could postulate that the positive impact of destigmatization is particularly advantageous for socially and economically disempowered women, as these women are less likely to have the resources to protect themselves from stigma. However, future research must pay special attention to the notion that higher disease surveillance among socially and economically disempowered women by the state and medical institution may also create other instances of structural disadvantages or powerlessness.

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## **Concluding Remarks**

This dissertation highlighted the specific gender regime of a community in rural Tamil Nadu, i.e., a pattern of systematic gender relations where women are in a subordinate position, both from an interpersonal and institutional perspective. This gender regime produces and is reproduced by a complex set of structural and cultural factors such as the gendered division of labor and women's restricted mobility in public spaces, intimate partner violence, control over reproductive lives and bodies, and perceptions of women's sexuality. In this dissertation, I parsed out some of these factors and the ways in which they intersect to constrain women's health, wellbeing, and personal safety in rural Tamil Nadu, India.

It is useful to start with tracing the dimensions of the local gender regime in this community, as it constitutes the background against which the TNHSP's cervical cancer screening program is being implemented. In addition to cervical cancer screening program implementation issues that have been identified and addressed in this dissertation, other factors that undermine this program may be linked to the fact that it is being implemented in a society where there are significant gender inequities. Although this dissertation has addressed various aspects of inquiry in this area, there is a necessity for further research in order to inform implementation of other women's health programs in Tamil Nadu, specifically in rural communities.

Findings from this dissertation also demonstrated that patriarchy in this community is pervasive and continuously reproduced. Women are not only subordinate to men, but also to other women; we see this not only in how women health workers' behaviors are dictated by and explained through patriarchy in the medical institution, but also in instances where women convinced their female relatives to return to marital relationships that were strife with intimate partner violence. Understanding the gendered power dynamics at play provides insights into

potential barriers to future implementation of programs intended to enhance women's health and wellbeing, at the community, institutional, and interpersonal levels.

Findings from this dissertation in combination with a review of existing scholarly work emphasized important areas that require further research and program or policy implementation. First, in the area of women's work, there is a strong need for research, policy, and program planning that aims to mitigate women's disproportionate burden of paid and unpaid labor within and outside their homes by facilitating gender sensitization about women's work roles and adverse health effects women face due to being overworked. Moreover, there is a need for research and program planning that aims to engage men in household and caregiving work, therefore easing women's burden and promoting equitable work roles within households and families.

Second, despite significant efforts by researchers, women's organizations, and policy makers in India, violence against women continues to be the one of the more prevailing forms of women's oppression, undermining women's overall wellbeing and development (Government of Jammu and Kashmir Civil Secretariat - Law Department, 2010; Johnson & Johnson, 2001; Nanda et al., 2014). There is an imperative need for research that provides insights into how women's experiences of marital physical and sexual violence intersect with traditional and patriarchal gender norms and societal expectations of women. Particular attention should be given to the fact that women who do experience violence often tend to normalize IPV. Furthermore, recent media reports indicate that societal constraints on women's abilities to end their abusive marriages and start new lives strongly lend to decreased instances of IPV reporting to police. Therefore, it appears as though police reporting occurs most often in instances where there is little or no chance of marital reconciliation (see Vandhana, 2013). Research and policy must closely consider the circumstances under which women experience, self-identify (to themselves and to others),

normalize, and report IPV. This is particularly important for shaping relevant policy and legislation to address marital physical and sexual violence that is locally relevant to the lived realities of Indian women. Additionally, although groups such as the National Commission for Women in India have been vocal about marital rape and have drawn attention among policy makers, there is substantial work to be done in this area in order to have marital rape not only recognized, but criminalized in practice (Bhat & Ullman, 2014; Raj & McDougal, 2014).

Furthermore, inconclusive evidence for links between women's empowerment and IPV in India prompts the need for further research that uncovers the nature of the relationship, keeping in mind salient changes in the political economy of India that affect gender relations. The existing gaps in the literature also raise two important issues regarding women's empowerment and IPV: 1. Are findings that indicate that increased empowerment leads to higher IPV reflective of a temporary period of transition in response to shifts in the socio-cultural fabric of rigid and oppressive gender relations and norms in India, or 2. Are they indicative of a larger phenomenon at play that must be addressed with other approaches in addition to development-driven agendas for women's empowerment? Furthermore, does increasing women's power and agency in one domain lead to reduced power in other domains, and if so, how may policy and program planning counter this? Future research, program planning, and policy work in India must carefully consider these questions and their implications at the aggregate community level as well as at the individual level. Moreover, although this review does not address IPV in unmarried romantic relationships, these relationships are becoming more commonplace in India (IIPS & Population Council, 2010). Policies and programs related to women's wellbeing in India often fail to account for this reality, therefore research on IPV must also extend to these relationships. In addition, there is also a notable dearth of research that links covert contraceptive use to IPV in India, particularly given current



economic shifts among Indian women (for example, increased participation in the paid work force) and the influences these shifts may have on women's reproductive decision-making powers.

As is inherent in qualitative research, during the course of fieldwork, data analysis, and dissertation writing, I had several moments of hindsight with regard to research design as well as research inquiries. In light of these insights, some changes I would have made in research design include clear stratification by caste, type of marriage, and age of women respondents - as opposed to age at marriage, type of household, and last visit to a clinic based on my original research questions. My data in this dissertation was insufficient in many cases to ascertain whether there were variations based on caste or type of marriage (arranged or love marriage). However, it is possible to speculate that a careful sample selection keeping these potential variables in mind may render visible clear patterns of women's constraints and agency based on caste or type of marriage. Additionally, I believe that a sample that is representative of multiple age groups among women may have made it possible to explore whether structural and normative constraints among women lessened (or worsened) over generations. This is particularly salient given recent changes in the political economy in rural Tamil Nadu that have resulted in higher employment rates among women overall. Moreover, it was challenging to measure social class in this study due to a combination of issues: irregular and inconsistent income generation due to the nature of agricultural work, shared household income in joint families rather than individual incomes in nuclear families, and government provisions and subsidies such as cement (rather than thatched) houses, gas, and televisions among others. It is interesting to consider the intersectional dynamic between social class and caste as an analytic tool in this study, given the overall low socioeconomic status of the community members.

Finally, findings from this dissertation prompt my interest in two major areas of future research inquiry in this community: 1. Women's navigation of the medical system and 2. How masculine, gender, and sexual ideologies shape IPV among men. Although my dissertation delineated gaps in implementation of the cervical cancer screening protocol from an institutional perspective, my research did not explore navigation of and resistance to medical regimes from women's perspectives directly. Research in this area would be instrumental to program planning and implementation of women's health programs that are both beneficial for and respectful of women's bodies in rural India. Additionally, despite the high prevalence of IPV in this community, this dissertation was unable to closely examine the influence of the intersection of masculinity, sexuality, and gender inequities on IPV in rural Tamil Nadu due to limitations on gathering men's perspectives. Although research on women's experiences and attitudes is key, it must be complemented with research on men's motivations, constraints, and attitudes for effective future intervention work that serves women's health and wellbeing.

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## **APPENDIX A. Regional Context for Study Site**

This doctoral research was conducted in the Thanjavur district, in the state of Tamil Nadu. Tamil Nadu is a large state in India, covering 130,000 square kilometers on the South-eastern coast of India. Tamil Nadu has a population of 72 million as of 2011, and 65 percent of the population is 15 to 59 years of age (Census Organization of India, 2011). The area comprising modern Tamil Nadu has been under continuous human habitation from pre-historic times, with several dynasties enabling an evolution of a strong regional culture and the formation of a Tamil language-based identity (Peregrine & Ember, 2003). Tamil Nadu has been, and continues to be, a predominantly Hindu state where Hindus comprise a majority (88 percent) of the population (Census Organization of India, 2011).

Both Tamil Nadu (as a state) and Thanjavur (as a district) have certain interesting state and district level features that implicitly impact the context of this doctoral research. Some of these features are identified and discussed below.

### **Economics and Development**

The major sources of income in Tamil Nadu are agriculture, manufacturing, non-manufacturing (for example, construction, mining, electricity generation, and trade), and services (Government of Tamil Nadu, 2014). With regard to economic development, Tamil Nadu is India's second largest state in terms of domestic product, and has the highest number of business enterprises and second highest employment figures in India (Census Organization of India, 2011). Overall economic development in Tamil Nadu has translated into relatively higher income levels: in 2013-2014, Tamil Nadu had a per capita income of approximately \$1850, compared to the national average of approximately \$1250 (Government of Tamil Nadu, 2014).

Apart from higher average income levels, Tamil Nadu has a strong record with regard to human development by measures such as life expectancy, average and expected years of schooling, combined education index, and per capita income with purchase power parity compared to a US dollar. It ranks sixth in India on the human development index (HDI) (Suryanarayana, Agrawal, & Prabhu, 2011), and was ranked as the third most developed state in India based on a government released "Multidimensional Development Index" in 2013 (Ministry of Finance, 2013). Thanjavur compares well with the state average in overall developmental terms, with an HDI of 0.75 (Government of Tamil Nadu, 2014) compared to the state HDI of 0.77 (Drèze & Khera, 2012; Government of Tamil Nadu, 2014). However, within Tamil Nadu, Thanjavur is a relatively poor district with low per capita incomes at \$672; this is lower than both the Tamil Nadu and the Indian average (Government of Tamil Nadu, 2014).

### **Urbanization and Agriculture**

Tamil Nadu has a high population density at 555 people per square kilometer compared to the Indian average of 382 people per square kilometer. Moreover, the state ranks as the most urbanized state in India, with about 48 percent of the population residing in urban areas (Census Organization of India, 2011). Approximately 11 percent of income in Thanjavur is generated through agriculture and allied activities, compared to the state average of about nine percent. Agriculture in the state, earlier comprising over 11 percent of activity, has declined over the years to stand at around nine percent as of 2014, with the state increasingly engaged in the service and manufacturing sectors (Government of Tamil Nadu, 2014).

Thanjavur is one of the few districts in Tamil Nadu that does not have an urban agglomeration – 65 percent of the population in Thanjavur resides in rural areas, compared to only 52 percent in the state overall (Census Organization of India, 2011; Suribabu & Bhaskar, 2014).

Thanjavur stands out with a high population density of 705 people per square kilometer, despite not having significant urban agglomeration (Census Organization of India, 2011).

### **Politics and Governance**

Regional politics have strongly dominated Tamil Nadu with the focus on an undivided Dravidian group (Wyatt, 2013) - i.e., the politics of defining oneself as a member of a Dravidian or south Indian culture as opposed to an Aryan or north Indian culture. The two leading parties are DMK (Dravida Munnetra Kazhagam) and AIADMK (All India Anna Dravida Munnetra Kazhagam). DMK was set up in 1949 with the stated aim of creating a space for the Tamil people, united by a single culture (Ramaswamy, 1997). More recently, there has been a move away from purely Dravidian focused politics (Pinto, 1999) to a strong focus on populist appeals (Subramanian, 2007; Swamy, 2003).

Although there are only a small number of independent caste-based political parties, caste remains a salient feature of Tamil Nadu politics. The leading parties, although integrating different caste groups within their structures, have become forerunners for the upward mobilization of lower castes through reservations (i.e., institutional quotas of admission, employment, or participation set aside specifically for disadvantaged groups) (Subramaniam, 2002). This remains a key feature of political discourse in Tamil Nadu today. As a state, Tamil Nadu has substantial reservations for minorities (up to 69 percent in all public sector or publicly funded institutions) (Kesri, 1994), and these groups comprise about 21 percent of the population (Census Organization of India, 2011).

It should be noted that Tamil Nadu has actively focused on policies aimed at improving governance and state effectiveness, and supporting women through access to education, employment, and financial credit, for example (Government of Tamil Nadu, 2007; Wyatt, 2013).

Recent findings place Tamil Nadu among the best performing states in India for a range of metrics related to governance and state effectiveness (Mundle, Chakraborty, Chowdhury, & Sikdar, 2012).

### **Gender and Development**

Tamil Nadu has a sex ratio of 996 women for every 1000 men. This ratio is relatively high compared to the rest of India, which has a sex ratio of 940. Moreover, Tamil Nadu has relatively high literacy rates, with male literacy at 87 percent and female literacy at 73 percent, compared to 80 percent and 65 percent nationally. Moreover, Thanjavur has relatively high literacy rates compared to Tamil Nadu overall, with male literacy at 95 percent and female literacy at 88 percent (Census Organization of India, 2011). However, it should be noted that in terms of income and gender-related disparity, Tamil Nadu, like most states in India, has substantial wage disparities across gender. In 2010, women in rural Tamil Nadu earned Rs. 161 (US\$ 2.44) per day, compared to men who earned Rs. 256 (US\$ 3.87) - i.e., a differential of 59 percent (Javeed & Manuhaar, 2013). Lastly, and notably, Thanjavur has an uncommonly inverted gender ratio, with 1035 women per 1000 men (Census Organization of India, 2011); this observation remains unexplained in the literature reviewed for the present study .

Tamil Nadu has been a frontrunner with regard to issues related to gender relative to other states in India. The early formation of a distinct department for women's development in 1983 (Tamil Nadu Corporate for the Development of Women) was a key move towards the empowerment of women (Seenivasan, 2013). In particular, the Government of Tamil Nadu explicitly recognized that education and employment for women is a cornerstone for development, and initiated several outreach interventions that ranged from free education to financing through self-help groups for women (Government of Tamil Nadu, 2007). Recent research indicates that Tamil Nadu is among the leading seven states in India on a variety of metrics pertaining to

women's empowerment such as labor force participation, gender equality related to work, and physical security and autonomy, driven in part by access to essential services and economic opportunities (Woetzel et al., 2015).

### **Health care**

Careful investment in health care and a strong implementation framework in Tamil Nadu have led to materially better health outcomes in the state compared to the rest of India. Over the last decade, Tamil Nadu has become a success paradigm for health care implementation in India (Gupta, Desikachari, Somanathan, & Padmanaban, 2009; Gupta et al., 2010; Malaney, 2000). Tamil Nadu established the Tamil Nadu Public Health Act in 1939 to provide a legislative basis to enable the implementation of policies that would support health provisions such as inspections, regulations, and monitoring. Additionally, Tamil Nadu is one of the only states in India to protect public health within a legislative fold, and the Department of Public Health and Preventive Medicines (DPHPM) has played a central role in carrying out public health-related activities and implementations (Gupta & Chowdhury, 2013).

Since 1994, Tamil Nadu has been able to pioneer a model of centralized procurement and decentralized distribution, thereby becoming a role model for the delivery of health care in India (Goleccha, 2015). In order to do so, Tamil Nadu created an independent accountable government corporation, the Tamil Nadu Medical Services Corporation (Narayanan, 2010), that would enable efficient centralized procurement of high quality medicines for government-run clinics. Prior to this, each medical facility had to follow its own sourcing path, with no quality standardization and at relatively high costs. The success of the Tamil Nadu Medical Services Corporation is demonstrated by the fact that by 2008, Tamil Nadu was able to increase the number of public primary health care facilities (PHCs) substantially, therefore serving only 32,000 people per PHC



compared to the national average of 49,000. Furthermore, the quality of Tamil Nadu's PHCs are notably better as evidenced by the fact that over 90 percent have pharmacists and functional operating theaters, compared to a national average of less than 70 percent. The efficient centralized drug procurement approach also enables 98 percent of Tamil Nadu PHCs to have essential drugs compared to the national average of 70 percent (Drèze & Sen, 2013). Furthermore, centralized procurement also enabled Tamil Nadu to become one of the earliest states in India to be able to set up universal health coverage in 1994, which is critical due to the fact that 86 percent of health expenditures in India are typically out-of-pocket (Malaney, 2000; The World Bank, 2015).

In order to distribute public health effectively, several steps were taken. In particular, the state separated all administrators into two categories - medical professionals and public health professionals - and mandated those on a public health "track" to acquire relevant educational qualifications in public health, therefore enabling a focused improvement in quality provision of public health. In addition, the universal health coverage program was funded through an efficient utilization of central government funds (through a public program called National Rural Health Mission), to operate primary health clinics that were functioning 24 hours/7 days a week and were free of cost (Gupta et al., 2010).

High quality governance and the use of several financial initiatives to increase access to and awareness of public health provision in the state have also driven Tamil Nadu's exceptional performance. It should be noted that the level of overall spending in Tamil Nadu is relatively low compared to other Indian states, especially given gains that have been achieved in health care (Gupta et al., 2010; Kumutha, Chitra, & Vidyasagar, 2014). As a result of focused state efforts, Tamil Nadu has reduced critical metrics such as maternal and infant mortality by 60 percent over

the last three decades, and is one of the few Indian states to have achieved the overall Millenium Development Goals (MDGs) set by the UN (Kumutha et al., 2014).

### **Concluding Remarks**

As is evident from the data presented above, there appears to be a discrepancy between the public data on advances in gender equity and health care and my own dissertation findings. This “tension” between my qualitative findings and public data raises several interesting points of debate and suggestions for further research. First, it is possible that pubic data in India, by its very nature, is biased to reflect favorably on public programs given the structural incentive to provide high performance results (I discuss this to some degree in my interpretations of the TNHSP’s cervical cancer screening program). Unfortunately, there are few sources of primary data that are independently collected and that may be used to cross-reference public data, especially at the state level. Some researchers have conducted independent research on the quality of health care in public and private health facilities, but this body of research focuses primarily on aspects of provider knowledge and effort, quality of practice and infrastructural constraints, and market failures in the provision of health care through both public and private channels. This research does not examine specific issues and biases in the reporting of public health data (Das, 2011; Das et al., 2012; Das & Hammer, 2014). Second, like in most other settings, women’s health indicators in Tamil Nadu, and India broadly, are likely reduced to maternal and child health outcomes (which affect a narrow age range of women at a specific interval in their life course that involves having children) that may not take into consideration health outcomes across the life span of women. Tamil Nadu’s health system has made notable efforts to achieve MDGs such as improvements in maternal and child health, yet these goals do not emphasize women’s health more comprehensively. For example, the MDGs do not include

the elimination of threats to women's personal safety such as IPV (or any kind of violence) or address women's cancers (or screening for cancers) (The World Bank, 2008). It is possible that my findings paint a bleak picture because they highlight aspects of women's health and wellbeing that are largely neglected in the MDGs. Filippi et al. (2006) provide a nuanced discussion on the implications of the MDGs on women's health in terms of financial and political priorities. These researchers explain that recent discussions around MDGs have shifted slightly from maternal health and towards infectious diseases, yet women's health specifically has remained invisible in the larger agenda. This is important to note, as even among other disease categories, women remain a disadvantaged and marginalized group with poor health outcomes in many settings. Third, and finally, although my dissertation research paints a dire picture of women's health in Tamil Nadu, one could argue that women in rural Tamil Nadu still fare significantly better in terms of gender equity and health outcomes compared to women in other rural parts of India. The established presence of a strong health system in Tamil Nadu in combination with relatively high sex ratios and literacy rates, and a state commitment towards women's empowerment, may provide a stronger foundation for women's health and gender equity in the state compared to the rest of India, albeit one that still requires substantial work.

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## **APPENDIX B. Reflexivity and Positionality in the Field**

In her ethnography on masculinity as a gendered and sexual process in high schools, C.J. Pascoe explains that she borrows from Mandell's (1988) notion of the “least-adult” researcher identity when studying children and creates a “least-gendered” researcher identity for her own research. Pascoe (2007) states that she positioned herself “as a woman who possessed masculine cultural capital” (p. 176), and performed a “soft-butuh lesbian demeanor” (p. 181) in both clothing and body language. She explains that she created this identity as a way to manage or mitigate uncomfortable or constraining interactions in the field while maintaining rapport and professional distance.

During my own fieldwork, especially early on, I found that my nationality (“American” or “Foreigner”) played an important part in facilitating, complicating, and ultimately shaping the research process and my researcher-respondent exchanges overall. My outsider status was noticeably confirmed by my apparent higher social class (based on my status as a researcher, my clean and pressed clothing, my use of a car to get to the village, and my access and familiarity with technology such as an expensive looking iPhone and laptop, for example), American accent, and skin color (which was much fairer than the norm in this region). Following in the footsteps of Mandell and Pascoe, I took on a “least-Indian/most-American” identity early in my fieldwork as I found that my outsider status inspired feelings of novelty, cautious/shy warmth, and curiosity (particularly among women who I interacted with directly), enabling more rapport-building and access to respondents and their time. Given the novelty of my “foreigner” and researcher identity, men’s and women’s expectations regarding cultural alignments (for example, clothing, body language, activities in the field, and communication with community members) were

minimal as they had fully expected that I would behave in a foreign manner corresponding to my foreign identity.

During fieldwork, I dressed myself such that I was not disrespectful or overtly thwarting gendered expectations, but I did not conform to social norms entirely. For example, I wore loosely fitting and unrevealing *salwar/kurta* (tunic and pants), which was common wear for the doctors at the clinics, but I did not wear a *chunni* (scarf draped across the chest for modesty) as the other women did. I also did not braid my hair or put it into a ponytail as other women in the clinic network or community did. I often had my hair in a “messy” bun if the weather was very hot (which it often was), or I would leave it down earlier in the mornings to let it air-dry. I wore minimal makeup (usually only eyeliner) like other women in the clinics and community, but I did not wear a *bindi* (dot on the forehead, between the eyebrows, worn by Hindu women except for those who are widowed) like most other women did.

There were at least three reasons why I decided to tread this liminal space between conformity and nonconformity. First, I found that maintaining my outsider and non-conformist status – especially earlier in fieldwork – actually made rapport building easier, while also allowing me freedoms that other women would not be allowed by providing me with the perceived excuse that I “did not know” what the proper way to be a woman was in this setting. Second, although it was spring in Thanjavur while I was conducting fieldwork, the weather was often oppressively hot and having to wear a *chunni* meant wearing another warm layer that added to the discomfort. Given the location and remoteness of the village, frequent electrical outages were a common occurrence during the day and the clinic only had three fans throughout the space. Moreover, the interview sites used for the study usually did not have any form of electrical cooling. Thirdly, I felt as though my choice of clothing and body language were the



closest I could get to resisting oppressive social norms of appropriate behaviors and bodily presentation for women during my time in the field without jeopardizing my research. In a sense, this was a form of “micro-resistance” I was performing that was an extension of other forms of resistance I have found myself performing throughout my adult life as an Indian American woman from a relatively conservative cultural background.

Although I did not entirely conform in some ways, I had no choice but to do so in others during my time at the study site – both for the sake of my research but also my personal safety in public spaces. My behavior in public spaces and my communication (or usually lack thereof) with men were the most obvious examples of when I performed conformity to gender norms. Initially during fieldwork, I made several attempts to get familiar with the village geography by walking around the space. The health workers at the private clinic as well as my translators were strongly opposed to letting me roam the village by myself, largely due to my outsider status in combination with my gender and obviously higher social class. Due to my affiliation with the private clinic, which made them gatekeepers to the community and gave me easy access to their patients in the waiting room, it was in my vested interest to respect certain concerns and boundaries that clinic staff emphasized. As soon as I arrived at the field site, the non-profit private clinic organization and their clinic staff took on roles of being my “protectors” and guides in the field. Their concern for my personal safety in combination with my desire to respect the clinic staff’s boundaries so as to maintain good relations meant that I was never alone during my time in the field. I was often accompanied by one of the translators or a member of the clinic staff. This was both useful as it lent me credibility in the field under the umbrella of the local medical institution, but also restrictive as my own mobility in the field was dependent on having a companion.

My general demeanor in the village spaces was respectful but often detached. I was friendly with women, especially those who had participated in the study or who I had spoken to while at the clinic, but refrained from verbal or eye contact with the men to the extent possible – keeping in line with social norms. The exception to this was when I was within the confines of the clinic waiting room and interacting with patients. Within clinic spaces, I was much friendlier and more open to conversation with men, especially if they were there with their wives. I gave a lot of thought to my “public-space” demeanor because early in my time in the field (and based on my experiences of living and visiting different parts of India), I got the sense that managing my presence and authority while navigating the field would be crucial to my ability to conduct research in two ways: 1. Careful presentation of demeanor was necessary so as to not “invite” negative attention, especially from men (which could also become a source of judgment from community women and jeopardize study participation by both genders), and 2. It was important not to attract negative attention from men as it would both be problematic for personal safety but could also threaten my social class-gender-researcher authority in the field and impact research activities. In outside spaces in the village, I often used a “distant gaze” - particularly around men - in order to not appear entirely demure (and subsequently unauthoritative) but also avoid eye contact with community men. This demeanor also contributed to a sense of disengagement with men in public spaces, as compared to my friendly engagement within the clinic space, which was useful to not only establish some sense of authority but also discouraged men from engaging with me directly or indirectly (via comments about or references to me that were meant for my ears). My social class and affiliation with the clinic staff was particularly useful in maintaining this distance for a long while during my fieldwork, and I found that men generally did not initiate unsolicited engagement with me during my time in the field.

It is important to note that, in contrast to my careful demeanor with men, I went out of my way to be overtly friendly with women – both within and outside of clinic spaces. I often made friendly “small talk” with women such as asking how they were doing, where they were headed, and how their children were doing. I believe this explicit engagement with women was an effective tool to build rapport with community women, unrestricted to only study participants. This proved to be an effective approach as I was often invited to their homes for tea or snacks. However, because the clinic health workers had warned me to avoid food and water in the village (I brought my own everyday) for health and sanitation reasons, I typically thanked women for their invitations but would express that I had to get back to the clinic but would love to see them again soon.

Over the course of my fieldwork - in perhaps a counterintuitive manner - my mobility in spaces of the village became increasingly restricted. As my presence in the field became more familiar to the community members, I began to notice that the initial respect and space that was afforded to me in public spaces began to diminish. This was quite challenging for me as both a woman and a researcher as it felt like a constant struggle against the local gender regime that dictated overt forms of patriarchy. My social class, status as a researcher, and affiliation with the clinic had protected me from many gendered expectations for a long while in the field, but over time and with familiarity, the relevance of these began to fade as my gender became the most important and relevant identity. As a result, my “micro-resistances” became less tolerable and I became more vulnerable to critique, the male gaze, and resentment even. This became apparent in the way men openly stared at me on the streets, made comments about me that were meant to be overheard (“she’s walking around everywhere again” or “go lady go”), and stared at me in groups through the clinic’s grill windows while drinking on the main street in the evenings. In

many of these situations, I felt as though I was being put in my place and being told who was in charge through practices of male domination that were meant to undermine my social status and reinforce my status as a woman first and foremost. Essentially, although my status in terms of being a researcher, of higher social class, and American put me higher in the social hierarchy compared to community men, my gender rendered me subordinate, therefore subjecting me to masculine forms of control.

There were also other instances that corroborated these shifts in my authority and social status as fieldwork progressed. About three months into my fieldwork (closer to the end of my fieldwork), during an informal conversation with one of the health workers, I mentioned that I had sensed a shift in the way the community members - particularly the men - were interacting with me. She postulated, “Now you’ve been here a long time and they will all expect you to behave like women are expected to here.” She went on to explain that if I were going to be in the field for much longer she would have asked me to begin wearing a *chunni* and leaving the clinic early in the afternoon (rather than early in the evening when the clinic closed) before the men returned from their agricultural work and started socializing in the main street.

In another instance, one day during fieldwork one of the translators and I had walked to a small ceremonial building we had been using for interviews only to find it padlocked after months of having had access to it. That evening around closing time at the clinic, a large and clearly drunk man entered the clinic and began walking towards me - with what I perceived as false deference - saying that he needed to talk to me. At this time, I was the only person in the clinic waiting room, and the health worker was inside the doctor’s office restocking medicines for the next day. I felt uncomfortable not only because he was drunk and I was alone, but because I recognized that this interaction put me at reputational risk. I noticed that the buzz of

conversation in the main street among men who were socializing and drinking had died down as they turned their attention to the clinic's grill windows to watch the interaction that was happening inside with me. Having sensed that something was amiss through the open door of the doctor's office, the health worker came outside and stood by me as she enquired about the problem. The man was responsible for locking and opening the ceremonial hall in the mornings and at night (a sort of security guard) and expressed that "it would be nice to have the hall painted before New Year's Eve" and that he could take the cash needed for the painting. Essentially, he was asking for a bribe from me in order to be able to use the hall for research purposes. Although I had no intention of engaging in a bribe, because I wanted to clarify what was being asked of me, I enquired about who I would need to speak with to clarify the issue. He insisted that he was the person in charge, which was clearly not the case as his role as the security person did not make him in charge of administrative building duties (as corroborated by the health worker). It was apparent that he was using my need for access to the building for research purposes as leverage to get a cash bribe for himself. I responded that I was not allowed to provide that kind of service and thanked him for informing me. After this incident, the health worker sought out a male respondent in the study, with whom she had a good social relationship and who had been receptive to my research activities, and encouraged him to let me use the storage room he used for his mini-mart as an interview space. From a research perspective, this was an interesting incident as it was a manifestation of the intersection of gender and social class. By approaching me while drunk, in public, and while other men could observe, the security guard had put me at physical and reputational risk based on my gender with several community men. Therefore, this was a strategic action on his part as it made me particularly vulnerable at the moment of interaction and more likely to be agreeable, if only to have the

interaction end as soon as possible. This was also an instance where my social class was actually detrimental to myself and my research activities, especially given my subordinate status as a woman.

My outsider status became distinctly problematic towards the end of my fieldwork when caste riots among two groups of young men broke out in the village late one evening in early January 2014. These young men were riding the local train from Thanjavur town to the village together when an argument between a few Scheduled and Backward caste men occurred. Once these men un-boarded the train, this argument escalated into physical violence among larger groups of men who had joined the fight as they saw it unfold in the village. The village had had severe caste riots with houses burned down several years ago and many study respondents had expressed (with both pride and trepidation of potential future unrest) that caste-relations had been relatively peaceful since that time. Following the riots, the village became very inactive and quiet, with policeman patrolling the main road several times a day and minimal foot traffic on the main road. The private clinic as well as other businesses on the main street saw very few patients and customers in the following two weeks, and it appeared as though community members were keeping close to their homes and agricultural fields for the most part. Soon after the riots, I continued to go to the clinic, but felt a distinct unease regarding my presence - both from health workers and the few community members with whom I interacted. A few days after the riots as the feelings of social instability in the village persevered, clinic health workers as well as some community members expressed concern for my safety (although I had not experienced any adverse situations related to the riots) and suggested that I complete the research as quickly as possible and refrain from visiting the village. I believe this concern was due to my status as an outsider, a young woman, and someone who was known to have asked numerous

questions about caste relations during formal interviews and informal conversations. Under the circumstances of social instability in the village, some community members and health workers viewed my outsider presence as endangering to myself and potentially contributing to the ongoing instability. I did not visit the field site for a week after these conversations arose, at which point the social atmosphere in the village had slowly returned to normal and I was able to commence the final parts of my fieldwork.

I believe I was never asked about my own caste identity despite being in a community that was extremely caste-aware because of my higher social class and overt outsider status based on accent, appearance, and nationality. It appeared as though the visible differences were so vast that my caste identity was less relevant to the men and women I was interacting with, including the health workers. I believe this was significantly beneficial to my research because - given that caste is a very relevant and often sensitive subject - I was generally treated as a neutral party within the discourse about caste, which fostered open conversations about the subject.

However, women respondents often asked me whether I was married, and when I responded that I was not married as yet, they would ask me when I was going to get married and have children. My translators and the health workers had asked me the same questions, and with these individuals I had felt more comfortable expressing my ambiguities around marriage and children. However, with women respondents, I would often respond vaguely saying “maybe sometime soon, I don’t know exactly when.” I believe that my gender in combination with my younger age and single status may have been problematic with my respondents (and subsequently my research) had it not been mitigated by my obvious outsider status and my affiliation with the female translators – particularly given the nature of my research, which included a focus on sexual behaviors. The involvement of married female translators in my research likely provided

legitimacy to my research and mitigated perceptions of inappropriateness (of interview questions) during my interviews. My female translators were married and had significantly more insider status based on their appearance, clothing, demeanor, language and dialect, and obvious familiarity with local social norms<sup>5</sup>.

While I found myself making efforts to downplay my unmarried status and its implications for my research activities, the male translator who assisted me in research and was a year older than me was able to leverage his unmarried status to build better rapport with the men. The community men took him under their wing as the unmarried young man who was learning about sex, women, and relationships from the more experienced men during interviews, and often jokingly teased him. For example, on his way to an afternoon interview with a male respondent, the translator said hello to a prior male respondent and this respondent chuckled and teasingly said, “Going for more fun time, eh? Good, good, you will learn things.” The male translator also explained that this type of younger and older brother dynamic was often present during interviews as well. Despite, and perhaps because of this dynamic, the male translator expressed feeling hesitant probing about particularly sensitive questions around sexual and physical violence for fear of appearing as though he was being overtly irreverent or judgmental. However, it is important to note that despite these limitations men volunteered valuable information on intimate partner violence. Furthermore, while some aspects of men’s interviews with the male translator reflected potential instances of masculine performance (i.e., an inter-male dynamic of the “experienced” men bragging to or educating the less experienced man), much of men’s accounts of violence and inter-family dynamics with regard to intimate partner violence appeared to reflect the reality of their experiences and perceptions.

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<sup>5</sup> My translators lived in town of Thanjavur, not the village site, but had been born and brought up or resided in the area for long enough to have become very familiar with the study site and the norms/expectations.



Finally, my affiliation with the clinic and its workers was also an important area of navigation as a researcher. My credibility as a researcher in the field was legitimized through my affiliation with the clinic and the presence of my “insider” translators. However, I also had to limit overt social interaction with clinic workers so I could establish my presence as a researcher independent of the clinic. This was particularly important as I was trying to understand institutional constraints on women’s health. I often had to repeatedly assure women respondents that the interviews were confidential and de-identified, and emphasize that any and all criticisms of the clinics and health workers would remain anonymous. I would often show them my field notes page, pointing to the area that had the respondent identification number without their names. In an attempt to facilitate trust-building and rapport with respondents, I was careful to keep my free time interactions with clinic workers at a minimum while also being friendly. For example, I often had lunch with the translators or by myself but avoided sitting with the staff during this time. I felt this was an important boundary to set as the grill windows in the clinic made all waiting room activities visible to anyone in the main street. I was also open with the clinic staff about needing to set myself apart from the clinic in small ways for research purposes, and they were very receptive to this decision. Additionally, I refrained from going into the doctor’s office as much as possible and spent most of my time in the clinic in the open waiting room. When necessary, clinic staff would approach me in the waiting room and speak in the open in most instances. I believed that this kind of interaction facilitated the perception of a more transparent dynamic between myself, clinic staff, and community members, while also locating me as a separate from the clinic staff.

Constant negotiation and renegotiation of my social status based on gender, age, marital status, social class, and status as “foreigner” and researcher was an innate and recursive process

during my time in the field. As result, I had to continuously be mindful of areas of tensions and boundaries that I or others were crossing. At different times, I would emphasize some combination of these characteristics to either maintain better rapport or mitigate constraints on my personal being or my research activities. This note is my attempt to delineate some instances in which I believe this process of negotiation impacted or shaped my dissertation research.

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